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FEEDING THE PREMATURE BABY*

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Until about 25 years ago the feeding of premature babies was a problem largely delegated to or appropriated by the nursing staff and strange and mysterious rites were observed in the process. There are no records to show how the babies fared under these circumstances but the acceptance by the obstetricians of paediatric help and the infiltration into maternity circles of nurses with paediatric training has improved the infants' prospects of survival. Progress has been slow but is based on facts, many of which are not generally known, and it is important that wider dissemination of some of these should be promoted. A few additional facts can be added to those which are already accepted. A meeting of large numbers of the medical profession, such as this, provides an opportunity for discussion of some of these points.

Prematurity is, of course, no rarity. Table I shows the incidence as stated by various writers. Salber *et al.*[1] gave figures of 4 - 18% in different racial groups in South Africa.

The observations for Cape Town (1955) are shown in Table II. Approximately three-quarters of the premature babies will be born alive and will have to be cared for. If the probable numbers for the city are calculated, it appears

TABLE I. INCIDENCE OF PREMATURITY

Levine[2]	(1950) 5%
Dunham[3]	(1955) 7%
Paterson and McCreary[4]	(1956) 6%
Salber[1]	(1953) — (4·2 - 18·3)
Cape Town Teaching Hospitals†	(1955) 8·4% (6·5 - 10·4)

† Total estimated figures (Cape Town) 8% of 16,000 = 1,300 annually.

TABLE II. PREMATURITY IN HOSPITALS OF CAPE TOWN OBSTETRIC TEACHING HOSPITALS GROUP, 1955

	Total births	*Prematures*		*Total as %*	*Race*
		live born	*still-born*		
Peninsula Mat. Hosp.	3,261	147	64	6·5	Col. and Afr.‡
New Somerset Hosp.	2,398	196	54	10·4	Col. and Afr.
St. Monica's Hosp.	1,353	112	26	10·2	Col. and Afr.
Mowbray Mat. Hosp.	1,031	71	9	8·0	White
Totals	8,043	526	153	8·4	
			679		

‡ Col.=Cape Coloured. Afr.=Bantu

that about 1,300 (8·4% of 16,000 births) are born each year, of which at least 1,000 will be live born, and since there is nothing like enough hospital accommodation a very large number must be cared for in the relatively few other establishments which undertake such work, or in their own homes.

* Paper presented at the 42nd South African Medical Congress (M.A.S.A.), East London, C.P. September - October 1959.

It is unfortunate that the general conception of adequate premature care visualizes a hospital, incubators, oxygen, special heating, etc. The main difficulty envisaged is that concerned with feeding. But there is really no necessity for such alarms, and my purpose is to show that a simple routine will yield excellent results if reasonable care is taken in the maintenance of body heat and in the prevention of infection.

Basically, a premature baby does not differ materially in the matter of feeding from any other infant. It needs fluid and all the usual constituents of any other infant's food. But feeding schedules which have been used in the past vary between gross deprivation of the baby in the early stages and attempts to fill it as full as a sausage later on. This is irrational, and investigation has shown that a more scientific basis for the feeding of prematures can be found. The minimum fluid requirement has been fairly accurately defined and the probable caloric needs are known approximately. Other details are in the process of being elucidated.

Gordon[5] showed that a fluid intake of 74 ml./kg./day (33·6 ml./lb.) produced a negative water balance while an intake of anything from 124 to 167 ml./kg./day (56 - 76 ml./lb.) resulted in a positive balance which did not increase proportionally to the intake. Translated into working practice this means that 2 oz./lb./day will be enough to allow of a positive water balance and a little less than that is probably allowable but risky. It also means that there is no need to exceed this amount unless the infant shows some sign of water deprivation or its environment is being maintained at a high temperature. No advantage need be expected from a materially higher intake of fluid *per se*. On the other hand, if the stipulated amount is given from the commencement of feeding and the first two 'feeds' are water or 5% glucose, the so-called 'physiological' loss of weight will be minimized or avoided. This is to the baby's advantage since a 4-oz. loss of weight is equivalent to an extra week in the region of dangerously low weights.

The caloric requirement has been generally estimated at 55/lb./day but other assessments have been as high as 70/lb./day. Obviously, with breast milk, which will supply 20 calories per oz., it is going to be impossible to supply even the lesser figure of 55 cals. in a volume of 2 oz. and some sort of compromise must be sought. Any form of cow's milk will supply still fewer calories. From this difficulty has evolved a vast literature on the type of food which should be given and which will be compatible with the premature baby's digestive capacity. A compromise of some sort is indicated.

If the premature infant is provided with 2½ oz./lb./day of a feed which has a calorie value of roughly 20 cals./oz. both its fluid and caloric requirements will be catered for, not in an ideal way but in such a manner that the doctor in charge can have an easy mind on these matters. The child will be liable neither to the dangers of underhydration nor to those of overfilling and regurgitation. The nurse or junior hospital officer can be supplied with a standard list of feeds suited to

different premature weights and can proceed without further guidance. If the child does not thrive on this regime the fault is not likely to be a dietetic one and attention can be concentrated on the possibilities of acquired or congenital disease.

The best type of food to be used is another matter. Breast milk has been severely criticised because of its low protein and low mineral content. Full-cream cow's milk has not met with general approval because of the difficulties which premature babies have with the digestion of its casein and fat and also because of the large amounts of phosphate which it contains. It has been suggested that a mixture of human and cow's milk, or one of human milk reinforced by casein, or special casein digests, or an amino-acid mixture is an improvement (Magnussen[6]). All such combinations may be readily available in hospitals in big cities but are not likely to be obtainable at short notice elsewhere.

My own experience does not make me enthusiastic over any of these complicated feeds, and the risk of mistakes in their preparation for the baby does nothing to advance their claims. It has been shown that, used in the above regime, any one of the following 4 feeds in pure form, viz. (1) breast milk, (2) full-cream evaporated milk, (3) a dried half-cream milk with added sugar, and (4) a so-called humanized milk,

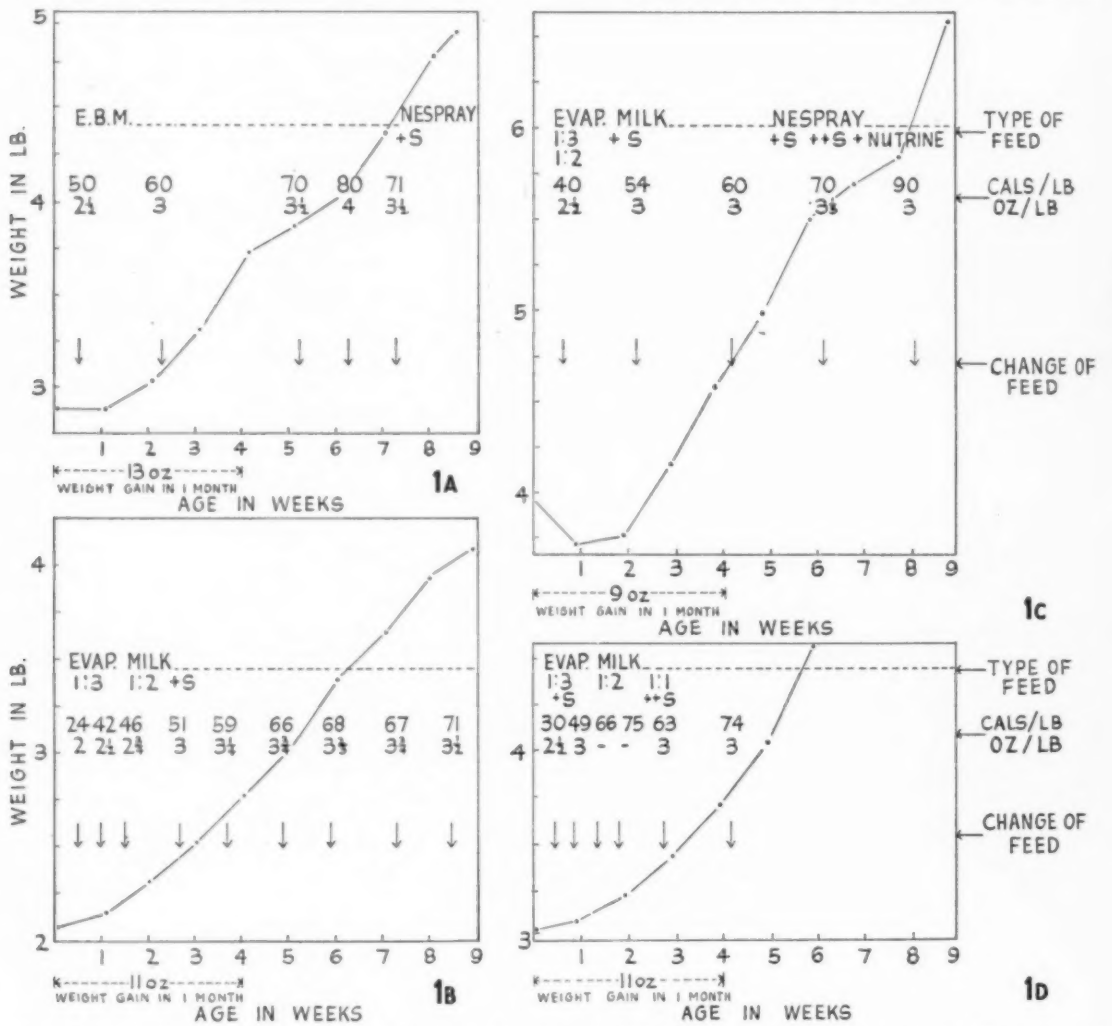

Fig. 1. Feeding of premature babies. E.B.M.=expressed breast milk. Cals./lb.=calories for lb. body-weight. +S=one-quarter teaspoonful of sugar per feed. ++S=one-half-teaspoonful of sugar per feed.

(A) K., born 26 March 1958. Peninsula Maternity Hospital.
(B) Buy., born 6 April 1959. Red Cross War Memorial Children's Hospital.
(C) Bul., born 14 April 1959. Red Cross War Memorial Children's Hospital.
(D) P., born 28 June 1959. Red Cross War Memorial Children's Hospital.

produces a weight curve which cannot be differentiated from that produced by any of the other three (Ford[7]). But with any of them it is impossible to obtain the suggested optimum caloric content in the allowable volume of fluid, i.e. 2½ oz./lb./day. Therefore, if this optimum is adhered to a caloric addition without increase in volume is needed. This should not be considered before the end of the first week of life but, when desired, it can be arranged for by adding about 1 g. of one of the commercial preparations of casein digest (casein-carbohydrate powder) per oz. of breast milk, or 1 g. of sugar per oz. of evaporated milk. This raises the calorie value to 23/oz., and the 2½ oz./lb./day will supply 58 cals. per lb. of body weight, a modest increase over the stipulated minimum requirement of 55 cals./lb./day mentioned above.

There is another way of getting over the deficiency in calories, but it is unwise to use it until after the end of the first week of life and then unless the baby is showing that a feed of 2½ oz./lb./day is well within its capacity and powers of digestion. This method is to give 3 oz./lb./day, in full knowledge that the child does not normally require this amount of fluid and will discard a large proportion of it in the urine. If the reinforced feeds are used the baby will be receiving 69 calories/lb. body-weight. The calories supplied at different times in the development of a few babies are shown in Fig. 1 (A, B, C and D).

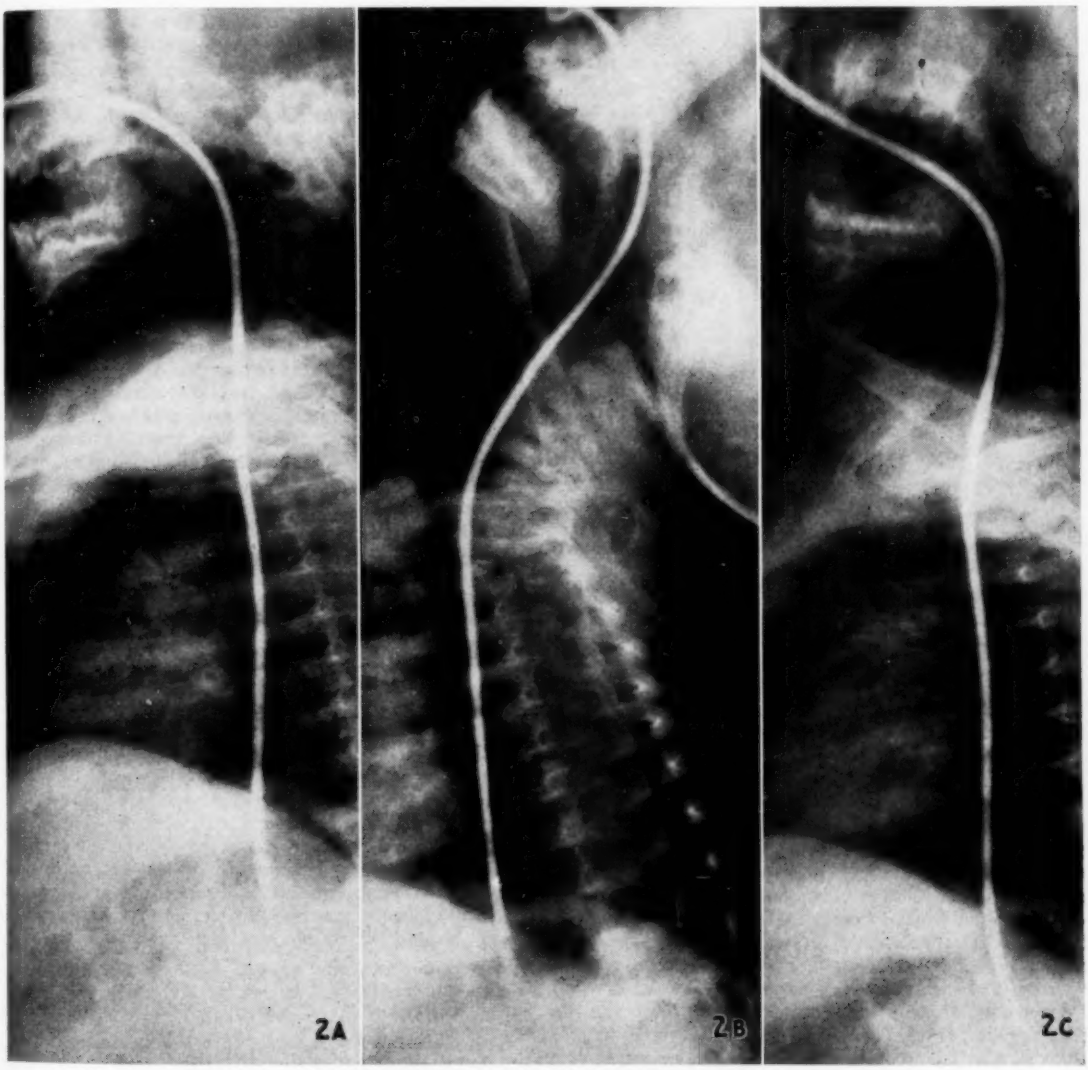

Fig. 2. Gavage tube. Length: tip of xyphoid to suprasternal notch × 2, plus 1 inch.

A. Nasal tube. Head upright. Distance mark at margin of nostril.
B. Nasal tube. Neck in full extension.
C. Oral tube. Head upright. Distance mark at gum margin.

The analytical details of the suggested feeds are shown in the following table and diagram (Fig. 3).

SUITABLE FEEDS FOR PREMATURE BABIES

	Total content of 3 oz. in g.			
	Prot.	*Carb.*	*Fat*	*Cals.*
3 oz./lb./d. breast milk + 'digest'*	2·7	8·7	3	70
3 oz./lb./d. evap. milk + sugar†	3	7·8	3	68

* 'digest' added: one quarter teaspoonful (approx. 1 g.) per oz.
† sugar added: one quarter teaspoonful (approx. 1 g.) per oz.

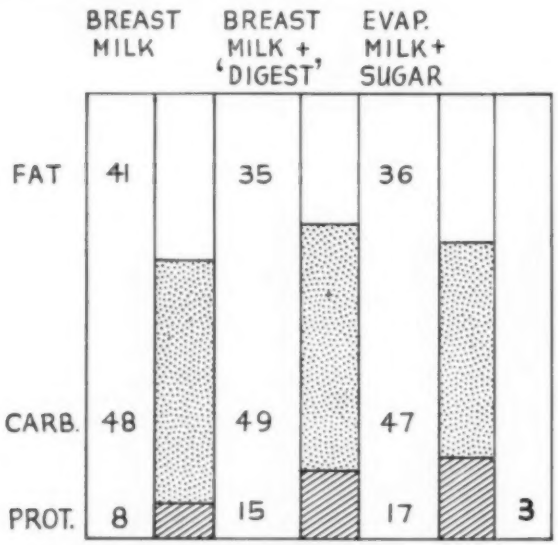

Fig. 3. Showing source of 100 calories in each of 3 food mixtures. Carb.=carbohydrate. Prot.=protein.

The schedule suggested is so simple that a general-trained nurse can master the details in a few minutes. It has now stood the test of time for about 15 years, in two hemispheres, and there is no apparent reason to make any radical change. The number of feeds to be given is laid down empirically as 8 per day for any baby under 4½ lb. birth-weight, 7 from 4½ to 5½ lb., and 5 thereafter.

The infants were tube fed, as most prematures have to be. The matter of technique in tube feeding is of some importance but there does not seem to be any authoritative statement about how far the tube should be passed. The time-honoured method (typically feminine), of measuring the tube against the child, with the tip against the substernal notch and the upper mark made at the level of the base of the nose, or after the tube has been led across from the mouth to the ear, is grossly inaccurate. The inaccuracy arises from the attempt to determine the distance between a fixed point and a moveable one. After considerable effort it became apparent that two fixed points could be used which are easily found and proportional to each individual baby. The distance between the upper edge of the manubrium sterni and the tip of the xyphoid process is a little short of half the required length. If this distance is doubled and an inch added and the mark made on the tube at that point, it will be found that, when the tube is passed nasally and the mark fixed at the margin of the nostril (or, with an oral tube, the gum margin), the tip has just passed through the diaphragm. To be quite certain that there is no danger of passing the feed into the oesophagus and, contrariwise, to avoid an excessive amount of tubing in the stomach, the manubrial-xyphoid distance should be doubled and 2 inches added. This is within the competence of any trained nurse. There is no danger of passing even a small tube unwittingly into the trachea since the small premature babies, in whom very small tubes are required, have such a small laryngeal aperture that the tube will produce immediate and considerable obstruction and distress.

The X-ray illustrations (Fig. 2—A, B and C) demonstrate the validity of this routine. The addition of 2 inches to the measurement on the chest makes sufficient allowance for movement of the head and neck during gavage. The tip of the tube can be guaranteed to be in the stomach but not too far in to permit it to act as a mechanical irritant. The plastic stomach tubes now readily available can be strapped to the baby's face and left in place for several days. In a country practice a no. 6 - 8 rubber catheter can be used until a plastic tube is obtained. There will be no great delay since, in any case, the child need not be given any fluid at all for 36 hours after birth.

The application of this technique would allow many premature babies to be cared for at home or in nursing institutions which have no special facilities for them, and avoid the risks of infection and chilling to which they are almost inevitably exposed when transport to one of the bigger centres is undertaken. The feed is easily obtained, breast milk or evaporated milk. The doctor can, if no other arrangements are possible, change the tube twice weekly, and any competent person can be quickly taught how to run in the feed at the required intervals. The baby should be propped up before the feed is started and left undisturbed for 20 minutes afterwards. It is impossible to run the feed too rapidly by gravity through a small tube and there is no need, therefore, to prescribe a minimum duration for the feeding operation. The main danger is infection, and this is the aspect which cannot be over-emphasized. The most scrupulous hygiene is essential.

SUMMARY

A simple way of feeding premature babies is outlined. It is based on a preliminary period of 36 hours in which nothing need be given. From that time a fluid intake of 2½ oz./lb./day is maintained. After one week this may be increased to 3 oz./lb./day. The inadequacy of the caloric intake with these quantities, when breast milk or evaporated cow's milk is used, may produce a rather slow gain in weight. If so, the breast milk can be reinforced with a casein—carbohydrate powder in the proportion of 1 g. per oz. and the evaporated milk with sugar in similar amount. The stomach tube should be passed to a mark made at a distance from the tip which is equal to twice the length of the sternum plus 2 inches. The mark should be fixed at the nostril or gum margin.

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VAN DIE REDAKSIE : EDITORIAL

DIE AFNEEM VAN SIELKUNDIGE TOETSE

By geleentheid van die onlangse Sitting van die Federale Raad van die Mediese Vereniging in Pretoria (3 - 5 Maart 1960) het die Groep Neuroloë, Psigiaters en Neurochirurge die volgende besluit van die Groep aan die Raad voorgelê: ‚Dat die gevare wat verbonde is aan die afneem van sielkundige toetse, aan psigometrie, en aan die interpretasie van projektiewe tegnieke, deur persone wat ongeskool is in die gebruik van hierdie tegnieke, onder die aandag gebring word van daardie lede van die mediese professie wat die toetse en tegnieke toepas. Verkeerde uitleg kan lei tot ernstige gevare vir die pasiënt'.

Sielkundige toetse en tegnieke van verskillende aard is van groot waarde by die bestudering en taksering van die verstandelike, emosionele en maatskaplike ontwikkeling van 'n persoon en van sy ‚sielkundige' toestand. Dit spreek dus vanself dat die belang van die tegnieke veral daarin lê dat hulle hulpmiddels is by die bepaling en omskrywing van afwykende persoonlikheidsgesteldhede.

Vir die oningewyde mag dit soms voorkom dat die toepassing en afneem van sielkundige toetse en tegnieke eenvoudig is. Die feit van die saak is egter dat dit nie so is nie. Alhoewel die afneem van toetse self skynbaar eenvoudig is, is die hele atmosfeer en benadering van die toets-situasie van die allergrootste belang. Groot versigtigheid en omsigtigheid moet beoefen word sowel wat die toepassing as die interpretasie van die resultate betref. Hierdie oorwegings is veral van belang waar die afneem van toetse deel vorm van 'n kliniese ondersoek op grond waarvan die toekomstige hantering en behandeling van die geval gegrond moet word.

Sielkundige toetse bied nie 'n kortpad tot 'n diagnose nie. Hulle is slegs bykomstige hulpmiddels en, om in staat te wees om sielkundige toetse na waarde te gebruik, is dit nodig vir die persoon wat die toetse toepas en interpreteer om genoegsame kennis te dra van die wye omvang van sielkundige tegnieke en van die teoretiese agtergrond waarop hulle berus. Ook is dit nodig dat die toetsafnemer die vermoë moet besit om die resultate as integrale deel van die wyere persoonlikheidsfunksies te sien teen die agtergrond van 'n deeglike kennis van die volle persoonlikheid en die milieu van die pasiënt. By die toetsafnemers veronderstel hierdie vermoë 'n grondige kennis van sielkundige konsepte en teorieë en 'n daaropvolgende, meer gespesialiseerde, opleiding in die beginsels van die toets-tegniek self. Omdat hy ten volle bewus is van die gevare van die gebruik van sielkundige prosedures deur persone wat slegs oppervlakkige kennis daarvan dra, het die Suid-Afrikaanse Sielkundige Vereniging 'n minimum van vier jaar van basiese opleiding, gevolg deur twee verdere jare van spesialisasie, neergelê as vereiste vir die opleiding van kliniese sielkundiges.

Uit hoofde van sy opleiding is die kliniese sielkundige bewus van die waarde en van die tekortkominge van sielkundige toetse en tegnieke en hy sal elke geval wat buite die bestek van sy hantering val, verwys na die aangewese psigiatriese, neurologiese, of ander outoriteite. Dit is egter omdat dit blyk dat sielkundige toetse gebruik word, veral by die ondersoek van kinders, deur persone wat nie opgelei is om dit te doen nie—afgesien van hoe goed hulle kwalifikasies op hul eie gebied ook al mag wees—dat die aandag van die mediese professie op dié saak gevestig word.

Daar kan baie groot skade berokken word deur die toepassing van sielkundige tegnieke deur oningewyde persone. En misleidende bevindings en verkeerde uitleg kan nie net lei tot 'n verkeerde diagnose nie, maar dit kan ook tot gevolg hê dat die pasiënt die kans op die regte behandeling vir sy toestand moet ontbeer. In die belang van almal wat met die bestudering en behandeling te doen het van persone met gedragsafwykings, en ook veral in die belang van dokters self en van die pasiënte oor wie se wel en wee hulle moet besluit, wil ons ons vereenselwig met die pleidooi van die Groep Neuroloë, Psigiaters en Neurochirurge om ook op hierdie gebied die ou, aanvaarde beginsel te eerbiedig: skoenmaker, hou jou by jou lees!

THE APPLICATION OF PSYCHOLOGICAL TESTS AND TECHNIQUES

The following resolution from the Group of Neurologists, Psychiatrists and Neurosurgeons was submitted to the Federal Council at its meeting in Pretoria on 3 - 5 March 1960: 'That the dangers of psychological testing, psychometry and the use and interpretation of projective techniques by those untrained in these techniques be brought to the notice of those members of the medical profession administering them. Misinterpretation may result in grave danger to the patients'.

In an explanatory memorandum the Group pointed out that psychometric and other psychological techniques, such as projective tests, are of great value in the assessment of the intellectual, emotional and social development and the present status of the individual, and to assist in determining the degree and nature of deviations in any of these spheres where they occur.

The application of such tests and the derivation of a quantitative score from some of the tests may appear to be simple to the uninitiated. In actual practice the greatest care is, however, required both in the administration and interpretation of the test results. This is especially the case where the techniques are used in a clinical setting as a basis for diagnosis, prognosis and advice with regard to treatment and placement.

The application of psychological tests does not provide a short cut to a diagnosis. In order to use psychological tests beneficially, there must be a precise knowledge of a wide range of such procedures and their theoretical background and construction, an ability to integrate results, and an understanding of the individual's total personality and environmental setting. This implies, on the part of those who use the techniques, a thorough grasp of basic psychological concepts and theories as a preliminary to the more specialized training in the application and interpretation of tests. Fully cognizant of the danger of the use of psychological procedures by persons only superficially familiar with them, the South

African Psychological Association has laid down for clinical psychologists a minimum period of four years of basic training to be followed by two or more years of specialization.

The psychologist is aware both of the value and of the limitations of psychological tests and procedures and will consult with or refer cases to psychiatric, neurological or other specialists when the tools in his own professional field seem inadequate. There is evidence, however, that psychological tests are employed, particularly in the examination of children, by those who, however highly qualified in their own field, have no proper training in psychology.

Attention is drawn to the fact that the gravest harm can be done by casual application of psychological tests by an inexperienced or unqualified person. This may readily result in a misdiagnosis and thus deprive the child of correct treatment and training at a critical period of his development. The parents may be misinformed of the child's true condition, with most undesirable effects on both parent and child.

It is thus desirable that psychometric tests be employed only by such persons as are qualified by training and experience.

TAALRUBRIEK

Die Taalkomitee van die Geneeskundige Skool van die Universiteit van Stellenbosch stel voor om te gebruik:

1. Eng. (in)tolerance: Afr. *(on)verdraagsaamheid*, soos in glukose-onverdraagsaamheid. *Toleransie* en *intoleransie* is bekend genoeg ook buite die mediese wetenskap, maar ‚sê' niks wat (on)verdraagsaamheid nie ook sê nie.
2. Eng. barrier: Afr. *versperring*, bv. bloedversperring.
3. Eng. pigeon breast: Afr. *spits bors*, *hoenderbors*.
4. Eng. G.P.I. (General Paralysis of the Insane). Daar word besluit om voorlopig nie te vertaal nie en te bly by die Latyn: *Dementia paralytica*.
5. Eng. trait: Afr. *trek* (s.nw.).
6. Eng. pectoriloquy: Afr. *borsspraak*.
7. Eng. pads: Afr. sal, volgens die verband, verskillende woorde moet gebruik, bv. (sanitêre) *doekies*, *skutverband*, *kussinkie*, *druk-kussinkie*, *skutgips*, *skutspalk*.
8. Eng. stove-in (chest): Afr. *ingestampte* (borskas).
9. Eng. douche: Afr. *spoel* (ww.) en *spoeling* (s.nw.).
10. Eng. cortical necrosis: Afr. het drie gelykwaardige moontlikhede, nl. *kortikale nekrose*, *korteks-nekrose* en *skors-nekrose*. (Die koppelteken is net 'n fakultatiewe optiese hulp vir wie dit nodig het: 'n mens sou daarsonder so maklik kon lees: skorsnek-rose.)
11. Eng. cotyledon: Afr. *lob*, mv. *lobbe*.
12. Eng. axis-traction: Afr. *as-trekking*.
13. Eng. slap: Afr. *klop*, in aansluiting by Eng. snap en click: Afr. *Klap* en *klik* (in verband met hartgeluide).

'DRUNK-IN-CHARGE' : SOME MEDICO-LEGAL ASPECTS

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The motoring laws make it an offence for any person to drive a vehicle on a public road while under the influence of liquor or a narcotic drug. Arising out of this, one may ask: 'When is a person under the influence of liquor?'

It has been held and accepted in our Courts that a person is under the influence of liquor when the skill and judgment normally required in the manipulation of a motor-car is diminished or impaired as a direct result of the consumption of alcohol. This definition is a far cry from the old concept of the 'drunk-in-charge' motorist who presents a typical music-hall picture and who, in fact, is not commonly seen to-day. There is no doubt that the manipulation of the modern high-speed juggernaut along our streets and highways, beset with road signs, traffic lights, circles—not to mention the multitude of similarly powered vehicles—is at the best of times a task of some magnitude, requiring in addition to physical properties, such as sound vision, hearing, touch, sense of position, etc., higher attributes such as concentration, caution, muscular coordination and judgment. In other words, any factor which interferes with any one of these requirements will impair the ability of the driver to manipulate his vehicle with the necessary skill, so that he becomes a danger to himself and to others.

It seems to be generally agreed that driving performance begins to be impaired at a blood-alcohol level that is surprisingly low. Drew *et al.*[1] found that steering errors, particularly swings to the right, increase as soon as there is a measurable quantity of alcohol in the blood, and that there is an increasing tendency to make either too little or too much movement in negotiating a corner. The largest dose of alcohol given in Drew's experiments was 3 pints of beer or 5 fl. oz. of whisky, which raised the blood alcohol to 80 mg. per 100 c.c. (·08%)—less than that consumed by the vast majority of offenders seen at police stations. He also found that short tests were unreliable, and that reasonably long-lasting tests seemed to be necessary, unless the impairment was a gross one.

Cohen *et al.*[2] assessed the effects of alcohol on groups of bus-drivers working for the transport department of the Manchester Corporation. They found not only that the men's trustworthiness was impaired even after a small quantity of alcohol (less than 0·5 mg. per c.c.) but that their actual performance deteriorated, they were involved in greater hazards, and they displayed a false confidence in their driving abilities.

This 'sub-intoxicated' state is increasingly recognized today and, although the response by different people to the same concentration of alcohol varies widely, it is becoming appreciated that, at a certain concentration of alcohol in the tissues, signs of intoxication will become evident in anyone, irrespective of his degree of 'tolerance'.

Alcohol is the responsible factor in a large percentage of the motor-vehicle accidents and incidents attributed to 'negligent driving' which never come to the Courts as cases of 'drunken driving', for the reason that the effects of alcohol on human behaviour and performance are not sufficiently appreciated by the public or the police. Only persons who display the 'obvious' signs of intoxication, such as the unsteady posture, the thick speech, the smell of liquor, the blood-shot eyes, and the aberrations of behaviour, are placed under arrest; lesser degrees of intoxication may not be easily discerned and an obviously guilty person may go scot-free at a stage when he is actually 'incapable' of driving his car with appropriate skill.

The Courts attach a great deal of weight to the evidence given by the non-medical witnesses. It is they, and only they, who can testify (*a*) as to the driver of the vehicle, (*b*) the manner of his driving, and (*c*) the signs observed in him at the time of the 'incident' or immediately afterwards—perhaps long before the medical examiner has had a chance to observe him.

The final opinion on whether an accused person was capable of driving a car at the time of the 'incident' is left to the Court to decide: medical opinion can only testify to the condition of the accused at the time of the examination. Unfortunately the importance of the medical evidence has, in some respects, been overemphasized—to such an extent that, more often than not, the issue of a case turns upon it; and should it be contrary to the police opinion it is probable that no proceedings will be taken. The

Courts are, of course, not bound to accept the medical evidence, and cases have occurred where, for example, an accused has sobered up rapidly after his detention and a conviction has been obtained despite the medical evidence being in his favour. That the police are scrupulously fair in their dealings with 'drunken drivers' has been observed over a period of years and the opinion of an experienced charge-office sergeant is one that deserves the greatest possible respect.

CLINICAL ASPECTS

Almost invariably the accused person is taken to the district surgeon for medical examination. This examination, and the evidence given subsequently in Court by the district surgeon, has always been considered to be of the greatest importance and has been the target of many an onslaught on the part of the legal profession. In an effort by the defence to establish a case the medical witness is often bullied and badgered, his tests are closely examined, his findings are criticized, and hours are spent in the witness-box answering questions and comparing his opinions with those expressed by others—not only in the text-books and literature, but also in the Courts.

Perhaps sufficient emphasis has not been laid on the individual nature, from a clinical point of view, of every case. Moreover, it is often not appreciated that:

(*a*) a considerable period of time may elapse before an accused person is examined;

(*b*) the examiner may lack the necessary experience required in carrying out the various 'tests' and interpreting their significance; or the tests applied by the examiner may only be adequate for the cases of gross impairment, and may not demonstrate the lesser degrees; and

(*c*) the employment of different tests favoured by individual doctors must of necessity lead to conflicting opinions on their interpretation.

Speed limits were legalized years ago, and what is now sorely needed is an alcohol limit—a sort of 'Plimsoll' safety-line of alcohol in the human body.

It is not the purpose of this article to discuss the physiological aspects of intoxication, but a brief description of the medical examination is included. This should always be carried out in a large, well-lit room—preferably not in the charge office—and it is usual for the examiner to enter his findings on form 457 (Health) which serves as an aid to his memory when he enters the witness-box. If he neglects to enter a description under any one of the 17 items on this form, he may be questioned on his omission, so that it is imperative for the examiner to complete the form and to make additional notes enlarging on the particular faculty that he has tested and described.

The following is a useful guide in examining an accused person:

Gait. The doctor should if possible follow the accused into the room so that he can observe his gait and the way he turns, goes through the doorway, or walks up steps.

General appearances. Once inside the examining room, objective signs may be noted such as colouring, stance, odour of breath, and state of clothing.

History. It is important to ascertain from the accused (apart from his name, address, occupation, etc.) whether he understands the reason for his detention and the nature and purpose of the proposed examination, and whether he complains of illness or injury—past or present. He should be asked if he is willing to give an account of himself and his movements during the preceding few hours, and the circumstances leading up to his apprehension. In this way an opportunity is gained of assessing the speech of the accused, his general behaviour, his orientation, and his memory. This is one of the best tests of mental alertness and accurate cerebration. If these are normal his account of his movements should be clear, logical and consequential as regards time and place. There should be no 'gaps'.

Examination. This should be comprehensive and unhurried, and directed towards eliciting signs not only of intoxication but also of any pathological state that may reasonably be confused with alcoholism, e.g. head injuries; neurological conditions (such as epilepsy, cerebral vascular disease, Parkinson's disease—to mention a few); psychological disorders such as acute anxiety or hysteria; metabolic disorders such as diabetic pre-coma, hypoglycaemia, cholaemia and uraemia; effects of drugs, acting either *per se* on the individual or synergistically with alcohol; exposure to carbon monoxide; and, finally, high fever.

Herein lies the greatest value of an adequate clinical examination—not so much the definite diagnosis of intoxication, but the elimination (or confirmation) of the presence of non-alcoholic factors which may have been responsible for the alleged condition of the accused at the time of the 'incident'—as described by the non-medical witnesses.

The examination should commence with the taking of the temperature and pulse of the accused, followed by an inspection of his eyes, the size of the pupils and their reactions, and an inspection of his ears by means of an auriscope. The tongue is inspected, the presence or absence of teeth or dentures is noted, and the smell of the breath is confirmed. It should be remembered that certain drinks 'do not touch the breath', so that, while the presence of an alcoholic breath indicates consumption of alcohol, its absence does not necessarily indicate the reverse.

The accused should then strip down to the waist and his heart, lungs and abdomen should be examined, and the blood pressure recorded. His legs should be examined for any diseases or deformities that may interfere with his gait, and the knee reflexes (and if necessary those of the ankles) should be tested. If necessary, detailed examination of the entire central nervous system should be carried out. Finally, the urine should be collected and tested for albumen and sugar, and the accused should be weighed.

From the foregoing it will usually be possible to formulate some opinion on his powers of coordination and the manner in which his muscles react to the communications from the brain. The examiner should observe the manner in which the accused buttons or unbuttons his clothes, ties his shoe-laces, takes a cigarette and lights it, picks up small objects from the floor, and so on. Coordination should be further tested by asking the accused to close his eyes and place the tip of a finger on his nose, on the tip of another finger, or to various other named parts of the body. While his eyes are closed, Romberg's test may be performed. The value of Romberg's sign is questionable in these cases, because normal people may sway slightly when their eyes are closed and their heels placed together and, on the other hand, many obviously intoxicated persons are found to concentrate to such an extent as to not sway at all.

Other tests for coordination include the following: The accused can be asked to write down his name, address and occupation. (This, the writing test, could be done right at the beginning of the examination.) A fair assessment can be made only by comparing his writing with a sample written on another occasion. However, it is surprising what gross defects are often seen. Syllables and letters are often repeated or transposed, excessive up-and-down strokes are made and, often, the writing is hopelessly out of line. A simple arithmetical test can be given (depending on education) and the manner in which the calculation is performed may reveal obvious and gross incoordination. Another useful test is the 'Porteous maze test', in which the subject is given a pen or pencil and asked to draw in the path from a point outside to a point in the centre of a simple maze of the kind often found in children's comics and magazines.

The examiner should select whichever tests seem to him most suitable in the particular case. It is futile to subject an illiterate person to a writing or arithmetical test; on the other hand, the educated or intelligent person, who is just the man capable of handling himself in a difficult situation, is the one who should be subjected to tests of wider range and greater discrimination.

THE DIAGNOSIS

The examiner, having critically reviewed the clinical picture as a whole, may now be in a position to express his opinion of the accused's condition at the time of the examination. His opinion should be based solely on his clinical examination, and he should make a note accordingly on form 475 (Health) for future reference. Provided the examination is carried out shortly after the alleged 'incident', and that it is done thoroughly and discriminatingly, a decision should usually be possible. The examiner may be asked to express his opinion of the condition of the accused at the time of the 'incident'. He may be able to do this with reasonable accuracy by comparing his condition at the end of the examination with his condition at the beginning of the examination; or, if possible, by seeing the accused again 1 - 2 hours later. He may also be assisted by ascertaining the time of drinking—the time of the first and the time of the last drinks. Perhaps it would be considered unfair to question the accused directly on these points; however, there is no valid reason why an inference should not be

made from his conversation or his voluntary statements on the matter. The examiner should also remember that a person may be 'shocked into sobriety' in a manner of minutes. Although he is obviously intoxicated, the large quantity of adrenaline secreted as a result of the emergency that has arisen may temporarily counteract the effects of the alcohol, without influencing the amount present in the tissues or blood. This factor is one that diminishes the value of the clinical examination.

If the examiner should consider that an accused person is intoxicated he should note the degree of intoxication. It has always been my custom to classify my 'cases' into one of four groups, viz: (1) mildly inebriated, (2) markedly inebriated, (3) drunk, or (4) very drunk.

Table I shows the frequency of the clinical signs (as noted on Form 475) and the category into which each of 120 cases that I have examined was placed. Those cases were all encountered in actual medico-legal practice and are unselected, though, for obvious reasons, only cases in which the result of blood-alcohol determination are available have been included. In each case the clinical classification was made before the result of the blood-alcohol determination was known.

In 2 cases, low blood-alcohol levels 'confirmed' the absence of clinical intoxication. In one case no clinical opinion could be given. This was a case in which more than 2 hours had elapsed between an accident in which the accused was involved and the time of the examination. The accused was not prosecuted for drunken driving although his blood alcohol level was 150 mg. per 100 c.c. The details of this case were subsequently discussed with the non-medical witnesses, who were of opinion that the accused was definitely under the influence of alcohol at the time of the accident.

From Table I it becomes very apparent that no one sign in itself is pathognomonic of alcoholic intoxication. It also becomes apparent that signs such as Romberg's and disorientation of time and place are only of value in cases of actual drunkenness; also that 'disorders of dress' and 'vomiting' are of such rare occurrence as to be of no value in the case that presents the greatest difficulties, viz. the slightly inebriated person. This is the person who usually 'gets away with it'—the one who is often not 'certified' by the examiner; the man, in whom the only abnormal findings may be the diminution of critical self-awareness and powers of discrimination and judgment; the man, who, in fact, may be a greater danger on the road than the obviously intoxicated person. It is for such a person that the prolonged and more complicated tests are necessary.

Eye signs. In my opinion the combination of bloodshot eyes with dilated pupils (occasionally contracted) reacting poorly to light is very valuable evidence of intoxication—no matter what the stage. It is true that this combination is belittled by the defence—sometimes, indeed, little is made of it by the medical examiner. How often, though, is such a combination found in persons not under the influence of alcohol? I made a specific search for this combination in over 600 different and unselected normal persons, and did not find it in a single person.

BLOOD-ALCOHOL DETERMINATION

Table II shows the results of the blood-alcohol determination in each of the series of 120 cases. From consideration of this table, the following striking facts emerge:

1. That there is a correlation between the blood-alcohol level and the degree of intoxication present; the higher the blood alcohol the greater the degree of impairment. The table, however, also shows that there is a fairly marked variation in tolerance and in the ability of the subject to control the more obvious aberrations of his condition. Thus, of 13 persons with blood-alcohol levels of 0·21%, 3 showed only slight inebriation, 8 were markedly inebriated, 1 was drunk and 1 was very drunk.

2. That, although a person may be intoxicated at a blood-alcohol level below 0·15%, no person with a blood-alcohol level at or above this figure was found to be sober.

There is no doubt that the blood-alcohol level should be regarded as the official 'Plimsoll line' previously mentioned—not of the degree of impairment of the faculties, but simply of impairment.

A great deal has been written about 'critical' levels of blood alcohol—above which an individual is regarded as being 'under the influence'. These figures vary widely, ranging from 0·05% in Norway to 0·10% in France and Germany. No such official figure has yet been laid down in British law. In America it has long been maintained that indisputable proof of 'under the influence' exists when the alcohol in the blood reaches 0·15%,[3, 4] and both the National Safety Council and the American Medical Association have recommended that this should be recognized as the ceiling value;[5] the figure of 0·15% has in fact been officially adopted by most of the states of the USA.

In South Africa, no blood-alcohol standard has been adopted, and considerable differences of opinion are encountered amongst doctors and amongst lawyers. It is felt that the time has come when lines of demarcation between levels of blood alcohol can confidently be recommended. In my opinion the following standards would be

TABLE II. BLOOD-ALCOHOL LEVELS BY GROUPS (NO. OF CASES)

Blood alcohol (gs.%)	*Slight inebriation*	*Marked inebriation*	*Drunk*	*Very drunk*	*Not inebriated*	*No opinion*	*Total*
·08	–	–	–	–	1	–	1
·11	1	1*	–	–	–	–	2
·12	–	1*	–	–	1	–	2
·13	–	1*	1	–	–	–	2
·15	3	–	2	–	–	1	6
·16	1	3	–	–	–	–	4
·17	4	2	2	–	–	–	8
·18	1	9	3	–	–	–	13
·19	1	4	–	–	–	–	5
·20	5	7	1	–	–	–	13
·21	3	8	1	1	–	–	13
·22	–	5	3	–	–	–	8
·23	1	1	3	–	–	–	5
·24	1	1	5	–	–	–	7
·25	–	2	5	–	–	–	7
·26	–	1	3	1	–	–	5
·27	–	3	–	1	–	–	4
·28	1	1	–	–	–	–	2
·29	1	1	1	1	–	–	4
·30	1	2	2	2	–	–	7
·31	–	–	2	–	–	–	2
Total	24	53	34	6	2	1	120

*Plus drugs

TABLE I. COMMONLY ACCEPTED SIGNS OF INTOXICATION: CASES OF EACH TYPE OF DISORDER, BY GROUPS

Clinical Group	*No. of Cases*	*Speech*	*Smell*	*Pupils*	*Conjunctivae*	*Dress*	*Vomiting*	*Gait*	*Positive Romberg*	*Muscular incoordination*	*Behaviour*	*Disorientation (Time)*	*Disorientation (Place)*	*Memory*
Slight inebriation ..	24	20	18	21	22	0	0	15	0	22	11	4	2	14
Marked inebriation ..	53	50	52	49	49	7	1	53	11	53	41	24	12	53
Drunk	34	34	34	33	33	10	1	34	24	34	34	32	23	34
Very drunk	6	6	6	6	6	1	1	6	5	6	6	6	6	6
Not intoxicated ..	2	1	2	0	1	0	0	0	0	0	0	0	0	1
No opinion possible ..	1	0	1	1	1	0	0	0	0	0	1	0	0	0
Total	120	111	113	110	112	18	3	108	40	115	93	66	43	108

fair to all—would result in the guilty being punished and the innocent being freed:

(*a*) 0 – 0·10% (inclusive)—not under the influence of alcohol.
(*b*) 0·11 – 0·14% (inclusive)—possibly under the influence of alcohol.
(*c*) 0·15% and above—definitely under the influence of alcohol.

Our laws require that before a person can be convicted of drunken driving the Court must be satisfied that he is guilty of that crime beyond any reasonable doubt. Although there is no doubt whatever that blood tests are fair and objective, yet it may go against our sense of fair play and justice to accept a chemical test by itself as the last authoritative word concerning a driver's ability to manipulate his vehicle with the necessary 'skill and judgment'. There is, indeed, no danger of its being so accepted alone, because no case of this nature can proceed without the testimony of the non-medical witness or witnesses. Therefore, in terms of what has been postulated in this article, guilt beyond a reasonable doubt would be constituted by a blood-alcohol level of 0·15% or more, confirmed by the testimony of the lay witnesses *or* the medical examiner. Where the blood-alcohol level lies in the 'possible' level (0·11 – 0·14%) then positive confirmation will have to come from the lay witnesses *and* the medical examiner. In a person of average weight, the concentration of alcohol in the blood decreases by approximately 0·015% per hour. Taking this into account, no great difficulty will be experienced in calculating what a person's blood alcohol probably was at a particular time before the medical examination.

SUMMARY

1. The skill required for modern-day driving may be impaired by an amount of alcohol that is surprisingly small.
2. The 'sub-intoxicated' individual, who is frequently the most dangerous driver on the road, often escapes the consequences of his actions because it is not realized that his inability to drive properly is reached long before the stage where he is obviously intoxicated.
3. Methods of clinical examination are explained, and the value of the examination, as well as its deficiencies, are stressed.
4. The need for some 'Plimsoll line' as a safety test of alcohol in the human body is imperative.
5. Determination of the blood-alcohol level of an accused person is a fair, objective and accurate test. Blood-alcohol levels of 120 cases are shown and correlated with their clinical findings and classifications.
6. It is proposed that a blood-alcohol level of 0·15% or above, plus the presumption of intoxication, confirmed by either the lay or the medical witnesses, should constitute *prima facie* evidence of drunken driving; but that with levels between 0·11% and 0·14% (inclusive) the intoxication of the accused should be confirmed by evidence of his physical state from both medical and non-medical witnesses before he can be found guilty beyond any reasonable doubt.

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HOSPITAL TREATMENT OF ALCOHOL ADDICTION

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This paper describes the establishment of a hospital for the treatment of alcoholism and the clinical results after a year of functioning. During this time 180 in-patients were admitted and treated, and 105 additional patients were seen who were not admitted but given some alternative form of treatment.

Alcohol addiction remains a largely unsolved clinical problem. Not only is it uncertain how alcoholic patients should best be treated, but, even if a formula for treatment existed, it would still have to be adapted to the social conditions that apply in any particular locality. (A Transvaal hospital provides prolonged in-patient stay without emphasis on follow-up out-patient treatment after discharge). The method of treatment which this paper describes provides for brief in-patient hospitalization (each patient stayed in hospital for an average of 23·7 days), with prolonged and intensive out-patient treatment after discharge.

Alcoholism is not only a medical problem, but it also has important sociological aspects. The social and economic loss through alcoholism is a grave handicap to the community.[1,2] Regarding treatment of this widespread[3] medico-social disorder, the medical profession has taken a serious, often gravely pessimistic, view. In the affected individual, alcoholism complicates more deep-seated psychiatric illness of varying type.[4] However, in the alcohol addict the emotional disorder takes a secondary place to the disastrous and often fatal mental and physical effects of prolonged alcohol intake. Failures in treatment are common[5] and in many cases successes are obtained only after much effort and even then they must be regarded as tentative, because relapse is the spectre always hanging over the recovered alcoholic.

PARK ROAD HOSPITAL

After representation from the lay Council on Alcoholism, the churches and medical practitioners, the Cape Provincial Administration undertook to equip and run a hospital for the treatment of alcoholism. A steering-committee made recommendations for clinical organization and staffing, and on 20 March 1959 the Park Road Hospital, Rondebosch, Cape, was opened. There is accommodation for 30 in-patients, and out-patient facilities are arranged to provide supportive psychiatric treatment for patients once they are discharged. Clinical direction and medical staffing was given from the Department of Neurology and Psychiatry, Groote Schuur Hospital. A carefully selected and trained treatment team aimed at creating a specialized hospital atmosphere, in which each patient could discover the implications of his own status as an alcoholic, and receive active out-patient care after discharge.

Admission of Patients

Application for admission of a patient may be made by any social agency. Medical practitioners, social workers, probation officers, ministers of religion, magistrates, etc., on being contacted by an alcoholic seeking treatment, can telephone the full-time hospital doctor and obtain an appointment for the prospective patient. Patients are only admitted if they are regarded as good subjects for treatment with a reasonable chance of being helped. Medical treatment, which aims at interrupting the habituation to alcohol and afterwards aiding the patient in his adjustment to his problems without alcohol, cannot be tolerated by all alcoholics. Patients who come involuntarily, on the insistence of their family or the courts, or who present themselves and then deny that they are in fact alcoholic (i.e. hold that they can continue to drink with impunity) are not suitable cases. To benefit from the facilities provided by the hospital, the alcoholic must himself seek treatment and undertake to cooperate.

Many patients living outside the Cape Peninsula applied for admission, but they would not be able to participate in an important phase of the treatment programme: continued follow-up treatment after discharge. A few patients were prepared to live for a while in the Peninsula in order to accept the conditions of out-patient treatment.

Mr. X., a municipal employee in a distant town, was very eager to be admitted, and undertook to get permission from his Town Council for long leave so that he could find work in Cape Town and meet the requirement for out-patient therapy. He was admitted on 31 March 1959 and benefited from in-patient stay. He was much encouraged by his second wife.

He left hospital on 12 March to get an extension of leave. He then returned to hospital, the social worker continuing her efforts

to find a temporary post for him. He became depressed and discouraged as attempts to find a job for him failed. Then the City Council, Cape Town, was persuaded to employ him temporarily and he left hospital for his own lodgings in the home of a church deacon on 4 May 1959. After 2 months of group psychotherapy, while managing socially without alcohol, he returned home. His last letter indicated he is sober and satisfactorily adjusted at work and in his family life.

One hundred and five patients were not admitted to hospital, but were given out-patient treatment, usually in the form of individual out-patient interviews or antabuse therapy.

The Treatment Team

Every member of the treatment staff contributes to the total therapeutic atmosphere of the hospital. It is known that patients will not discuss their own anxiety-provoking conflicts if the staff is disorganized and fails to weld itself into a harmonious treatment team. A hierarchical ranking of the staff, with some members considering themselves above criticism, is counteracted. Frank discussion of irritating or anxiety-provoking behaviour in individual staff members is encouraged regardless of seniority or status. In this way free communication of hospital information is fostered. The role of each worker is defined as clearly as possible, and all are put in possession of the facts concerning the behaviour of patients and their treatment, so that ambiguity of therapeutic approach is reduced.

Once a week there is a staff meeting, where problems of individual patients are discussed openly, where policy is decided, and where inter-staff relationships receive attention. Conflicts of attitude or interest between different staff members are discussed frankly.

(*a*) *The medical staff.* The hospital is under clinical direction from the Department of Neurology and Psychiatry, Groote Schuur Hospital. There is a full-time medical officer (registrar) who is a psychiatrist in training. Four consultant psychiatrists each work 1 session per week, including the conducting of a long-term out-patient psychotherapeutic group. One consultant psychiatrist works 3 sessions a week, and conducts the nurses' group and a closed wives' group. All consultants also see individually in-patients allocated to their care.

(*b*) *The nursing staff.* Psychiatrically-trained nurses are very scarce in the Cape Province. Most members of the nursing staff have obtained their training in psychological handling of patients since starting work in the hospital. The staff consists of a matron, 2 sisters, 3 staff nurses, and a small number of nursing aides. Professionally-untrained nursing aides have proved of limited value and even an actual liability at times, because of their unprofessional interactions with patients and their incapacity to understand the limits of their role in treatment.

Most of the nurses have problems in handling alcoholic patients (who are often demanding and socially-provocative). Lacking training, they sometimes become excessively involved emotionally with disturbed patients. In the nurses' group each week, under regular direction from the same psychiatrist who encourages frank communication, the difficulties of treatment interaction receive detailed discussion, and the opportunity presents itself to teach the nursing staff about psychiatric treatment methods. Although all nursing appointments were made only after personal interviews with the psychiatrist in charge, many applicants had unsuitable motivations for this kind of work (father an alcoholic, need for personal psychiatric treatment, etc.). On a few occasions nurses, lacking the necessary psychiatric training, gratified their pathological needs for dependency by developing emotional attachments to patients.

(*c*) *The social worker.* The social worker's chief activity is supervising the social rehabilitation of the patients. The most onerous responsibility is helping patients to find employment. Most patients feel that their present, or prospective, employers should not know of their illness and treatment; they fear that if they are known to be alcoholic they will be distrusted and a stigma attach to them. Only some employers have been willing to co-operate actively with the hospital, urging the patient to come for treatment while keeping his job open for him. (Such cooperation with employers has made possible a very important advance in hospital treatment of alcoholism in the United States.[6]) There is no doubt that the hospital will attract the most promising type of patient only when employers accept the fact that the best patient is one who is still employed, is given leave to come to hospital and who, on return, can be thought of as on a type of probation, with active encouragement to continue with his out-patient treatment.

In addition to assisting the patient in his rehabilitation, the social worker undertakes psychiatric case work with the relatives. Some familes are very disrupted and call for much intervention in aiding their social readjustment.

The social worker has a key position in the functioning of the hospital and in maintaining contact with patients' relatives after discharge. She is usually approached by a relative if a patient has relapsed and is drinking again.

(*d*) *The occupational therapist* provides patients with the means for keeping themselves creatively occupied while in hospital. At first some men consider 'craftwork' unmanly, but soon participate when they witness the satisfaction that other patients derive from constructive activity. The occupational therapist observes and reports how individual patients behave while in occupational therapy, e.g. inability to complete a task and dependency in making work decisions. The hospital shop is under the supervision of the occupational therapist. She maintains contact with patients after their discharge through her supervision of the social club (which is conducted by the patients themselves).

THE METHOD OF TREATMENT

The organization of the hospital is on the lines of a therapeutic community.[7] Milieu therapy occurs with the democratic absence of barriers between patients and staff. The patients, to a varying degree, have been isolated and disorganized socially, and opportunity is provided in the hospital for the resumption of individual social responsibility by each patient. They associate closely with other alcoholics; frequently patients indicate what a beneficial effect is exerted by their realization, through their fellow-patients, that alcoholics are not evil and ostracized, but often likable people who can be respected. All members of the staff participate in counteracting the estrangement of newly-admitted patients, and in establishing communication with other patients on the one hand, and between patients and the medical and nursing staff on the other hand. As he becomes a responsive member of the hospital community, the patient becomes increasingly accessible to psychotherapy.

Group psychotherapy[8] is the main form of psychological treatment. Daily group meetings are held, conducted by the full-time medical officer 5 times weekly, and once weekly by the psychiatrist in charge. Newly-admitted patients soon gather from older in-patients the aims of treatment. Among the patients themselves a marked fellowship is achieved, and intimate problems and preoccupations are openly discussed. Confidential matters, which the patient feels constrained to ventilate more openly, can be discussed with the consultant psychiatrist to whom the patient is assigned and with whom he has individual interviews in addition to the common hospital treatment. Active medical care for physical disorders may be needed during the first few days of hospitalization. In Table I a summary is given of the nature and incidence of physical abnormalities present on admission.

TABLE I. PHYSICAL ABNORMALITIES PRESENT ON ADMISSION

History of periods of amnesia ('blackouts')	25·3%
Hepatomegaly	13·3%
History of epileptic seizures	12·6%
Peripheral neuritis	8%
Optic nerve dysfunction	2·6%
Limb incoordination	2%
Pancreatitis with cirrhosis of the liver	2 patients
Subdural haematoma	1 patient
Coronary thrombosis	1 patient
Diabetic pre-coma	1 patient

During his stay in hospital the patient is encouraged to explore his personal problems. He makes frequent contact with the nursing staff, who are being trained to encourage the confidences of patients and to point out where the patient's view of reality is a distorted one. Therapeutic relationships also spring up between the patients themselves who, in informal discussions with each other, make warm personal contacts. The total hospital atmosphere is aimed at encouraging communication. In addition the patient obtains a thorough understanding of the nature of alcoholism and of the fact that his only cure is to stop drinking altogether; he also becomes acquainted with what he should anticipate if he continues drinking.

Each patient is taught how to use antabuse,[9] learning that if he takes a tablet he confers upon himself a temporary inability to

drink; the tablet is non-toxic in therapeutic doses, but when combined with ingested alcohol a sudden and severe acetaldehyde poisioning results. For 36 hours after taking a tablet any alcohol ingested will lead to unpleasant effects.

The patient has contact with the social worker who sees his relatives, looks into his employment situation and may interview his employer. She may arrange for his wife to be seen by the psychiatrist who conducts the wives' group, to which the wife may be invited if suitable. The occupational therapist has daily contact with each patient. Every staff member is regarded as a significant part of the treatment team: it cannot be foretold to whom the patient will turn and with whom his most significant contact will be made.

Emphasis is placed on the need for continued treatment after discharge and that if drinking is resumed the patient should contact the hospital either for readmission, should the medical staff consider this appropriate, or to evaluate or modify the out-patient treatment plan. Any self-help in this capacity (e.g. attending Alcoholics Anonymous meetings) is also encouraged. Facilities for re-socialization occur through the social club. Contact with the surrounding community (for work, lodgings, etc.) is effected by the social worker and through the advisory committee.

The social club. Each Wednesday night the patients themselves organize a social event to which all patients, current in-patients as well as discharged patients, are invited. The social club has been successful since its inception; wives accompany patients, and a doctor attends to enable anybody with a problem to mention it. The occupational therapist takes organizing responsibility; the elected committee arranges the film, card game, concert, dance, supper party, etc. for each week. The meeting of the club is regular, so that patients who find difficulty in participating in active group psychotherapy still have this less demanding means of contact with the hospital open to them. Lonely, friendless patients and their wives are enabled to resume social contacts which may have been in abeyance for years.

The hospital shop was started with the dual intention of enabling patients to buy necessities on the premises, and at the same time to give them opportunities for democratic conduct of their own affairs. Two patients are elected to run the shop, which is under the supervision of the occupational therapist.

The wives' group, on the understanding that wives are involved in their husbands' drinking pattern, has given treatment to a selected number of wives. (The weekly open meeting provides another opportunity for treatment of relatives.) A wife expressing anxiety (either through her husband, or directly to a psychiatrist or the social worker) is invited to see the psychiatrist in charge of the wives' group. It is emphasized that the group functions intensively, and that it is not intended for casual members. Seventeen wives joined the group during the course of the year, and 12 attended for more than 4 sessions. An average of 10 attended at each meeting. Although the husbands' drinking problems featured prominently in the group discussions, the wives soon expressed the recognition that they were getting direct help with their own emotional difficulties. Each member was bringing to the group her own personal problems in her marriage to an alcoholic, and difficulties in the upbringing of her children. All the wives attending regularly over a period of months experienced personality changes within themselves which they said contributed to their families' happiness. This was particularly marked in a woman whose husband did not respond to treatment.

Mr. B., despite 2 admissions to the hospital, continued drinking. But Mrs. B.'s attendance at the wives' group enabled her to remain relatively calm through the successive domestic crises, and to protect her children from the accompanying strains. She could say 3 months ago that although her husband had not changed beyond getting a job, the family life had become reasonably happy, whereas previously they had all been miserable. Now that it is clear her husband will not keep a job and cannot control his addiction, she has competently arranged lodgings for herself and the children, has kept working, and has left him.

The weekly open meeting. A psychiatrist conducts a meeting on Thursday nights for alcoholic patients, their wives and any other relatives interested in obtaining information about alcoholism. Wives attend who have not yet succeeded in persuading their husbands to attend for treatment, in the meantime obtaining advice and also support in the domestic difficulties with which they are met. Some ex-in-patients, not able to cooperate in intensive group psychotherapy, attend this meeting.

Out-patient Follow-up Treatment

The most important part of the treatment is that occurring after discharge, when the patient is resuming his work and family responsibilities and is learning to conduct his affairs without recourse to alcohol.

Out-patient treatment consists of intensive psychotherapy in small closed groups. Groups consist of about 10 members and meet for 1½ hours weekly. The first group, now nearly a year old, has met for 50 sessions. Four out-patient groups are now in progress.

Some patients on discharge decided they have had enough help and attempt to manage on their own. Others drop out of their group after attending for a variable time, fail to reply to inquiring letters, and may be assumed to be drinking again. Sometimes such patients decide after months that they must take further steps for treatment, and either present at the hospital (when they may or may not be re-admitted) or alse re-attend the group to which they had been allocated. Twenty-eight of the 180 patients (15·6%) have been re-admitted. Antabuse tablets may be obtained from the hospital at the time of out-patient attendance.

RESULTS OF TREATMENT DURING THE FIRST YEAR

Personality Change

Modification in drinking habits is the primary goal of treatment, but the psychiatric treatment techniques used (chiefly group psychotherapy and milieu therapy) also aim at aiding the patient to change his personality patterns. The social adjustment of the patient is as much a matter for treatment as his alcohol addiction. His personal relationships are examined, and his problems in living with other people are explored. Successful treatment should lead to improved social adjustment.

Very marked changes have occurred in a number of patients. This type of psychiatric information, however, cannot be communicated statistically but only by description of individual patients. One patient, for instance, has lost his stammer in the hospital; an aggressive policeman has become a contented man who enjoys being helpful to others in his work; a senior psychiatric nurse has transferred to his own work the treatment methods which at the hospital led to his own improvement; an isolated, bitter woman has married; and so on. It is these changes in personal adjustment of individual patients which are most interesting to work for and observe when they occur, and which, of course, provide the treatment staff with incentive and satisfaction.

Change in Drinking Pattern

A follow-up study of all patients admitted up to 20 March 1960 has been made:

Total admissions during year ..	180
Re-admissions	28 (15·6%)
In direct contact	105 (58·3%)
In indirect contact	32 (17·8%)
Out of contact	38 (21·1%)
Deaths	5 (2·9%)

Direct contact implies that the patient himself had come for treatment or attended some hospital activity (e.g. social club) so that he was seen personally for checking on his present status. *Indirect contact* implies that a relative or close associate in immediate touch with the patient reported on his status. It will be seen that the hospital has lost all contact with only one-fifth of the patients admitted.

Eighteen of the patients (10%) were female.

Deaths. Five patients included in the above 180 have died during the time under review. One, in out-patient treatment and sober, died in a motor accident. Another, drinking status unknown, died of diabetes. A patient out of contact with the hospital (drinking unknown) died of cerebral haemorrhage; another, drinking status improved, of coronary thrombosis; and one patient, drinking status unknown, of cardiac failure.

Four categories of treatment-outcome have been used in clinical assessment: sober, improved, unchanged, not known.

Sober	87 (48·3%)
Improved	26 (14·4%)
Unchanged	39 (21·7%)
Not known	23 (12·8%)
Deaths	5 (2·9%)

Patients therefore known to have benefited from treatment during the course of a year number 62·7%. Only continued follow-up study will show how many maintain their improvement and for how long.

I should like to thank Dr. A. W. Falconer, Medical Superintendent, Park Road Hospital; Dr. S. Berman, Head of the Department of Neurology and Psychiatry, Groote Schuur Hospital; Dr. V. Rakoff, registrar; Dr. S. Wolff, psychiatrist; Dr. F. Ames, neurologist; Mrs. L. Holland, social worker; Miss J. MacKay, occupational therapist; and Sister E. Crowley, Acting Matron, Park Road Hospital.

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PROBLEME VAN DIE MEDIESE PRAKTYK*

G. F. C. TROSKIE, M.B., CH.B., *President, Tak Oranje-Vrystaat en Basoetoland (M.V.S.A.), 1959*

Daar is drie sake wat ek kortliks by hierdie geleentheid wil bespreek: Die eerste raak die publiek, die tweede meerendeels die mediese praktisyns, en die derde die individuele geneesheer.

Mediese Hulpskemas en Siekteversekering

Die eerste saak wat ek wil bespreek is die posisie in verband met mediese hulpskemas en siekteversekering.

As ons die mediese praktyk in Suid-Afrika objektief beskou, en ons hoef nie eers baie ver terug te gaan nie, dan vind ons dat daar hoofsaaklik drie soorte pasiënte is met wie die dokter te doen het:

1. Die private pasiënt wat in die meeste gevalle 'n ordentlike, beskaafde, opgevoede mens is wat die dokter nie onnodig en ontydig ontbied nie, sy instruksies stip nakom, en dan net so stip sy rekening betaal. Hierdie ideale pasiënt maak die ruggraat van elke praktyk uit, en dit is die moeite werd om hom te pamperlang en te behou.

Dr. Troskie

2. Die groep pasiënte wat feitlik van die hand tot die mond lewe, wat nie aldag genoeg eet nie en wat nie aldag genoeg weet nie; wat maklik die dokter roep en maklik sê hy moet die rekening stuur, en maklik vergeet om die rekening te betaal. Hulle het in die verlede 'n baie groot deel van elke mediese praktyk uitgemaak. Hulle is die groep wat meer oortollige adrenalien-uitskeiding veroorsaak as alle ander groepe saam. Hulle is die groep wat deurmekaar boer, dan by dié en dan by daardie; wat almal probeer, almal irriteer en self kripeer.

3. Die groep wat deur die Staat versorg word deur sy distriksgeneesheer-skemas, bygestaan deur daardie kollegas wat glo dat hulle 'n sekere getal advertensie-konsultasies gratis moet verrig; of te wel dat deel van hulle dag se arbeid *pro Deo* moet wees.

Nou is dit op die tweede groep pasiënte wat hierdie hulp- en versekeringskemas betrekking het. Ons vind dat daar sedert 1936 meer en meer mediese hulpskemas en bystandsfondse deur groot groepe gestig is, en dat die Mediese Vereniging hierdie skemas weldra goedgekeur het en ingestem het om hulle lede teen 'n verminderde tarief te behandel. In ruil hiervoor het die mediese hulpskemas gewaarborg dat die geneesheer wel besoldig sal word vir sulke dienste.

Aanvanklik was dit 'n beslommernis om altyd vorms in the vul en om dan nog minder betaal te word as vir gewone private pasiënte, maar, by nader ondersoek het die voordele die nadele tot so 'n mate oorskry dat die pasiënt wat aan 'n hulpskema behoort 'n populêre tipe pasiënt geword het. Terselfdertyd was dit ook vir die pasiënt 'n saak van rus en vrede om te weet dat die geneeskundige diens wel betaal is of grotendeels betaal word.

Gevolglik het gedurende die later veertiger- en vyftigerjare meer en meer mediese hulpskemas en bystandsfondse ontstaan. Die beginsel wat deurgaans gehandhaaf is, is vrye keuse van dokter sowel as van pasiënt.

Ons is egter ongelukkig almal mense met gebreke, en as gevolg van misbruike het hierdie skemas in finansiële moeilikhede beland. Hierdie misbruike het ontstaan van die kant van die publiek sowel as van die kant van die geneeshere. So, byvoorbeeld, was daar talle gevalle van 20 besoeke vir gewone masels (ongekompliseerd), of eise vir oop frakture waar slegs 'n toe kraak bestaan wat nie eers redusering nodig het nie. Selfs fiktiewe besoeke en behandeling word aangeteken om te vergoed vir die verskil tussen die goedgekeurde tarief en private gelde. Die gevolg was dus dat hierdie skemas òf hoër premies moes eis òf laer uitbetalings moes doen, of dat hulle die keuse van geneeshere moes beperk en voltydse of deeltydse gesalarieerde personeel aanstel om te kan likied bly.

Nie lank nie, of die mediese professie is nie tevrede met die gelde waarvoor hulle werk nie, en tariewe word opgeskuif. Onderhandelinge vind plaas en weer moet premies verhoog word, en so gaan dit aan totdat 'n punt bereik is waar (in sekere dele van die land) die hulpskemas tot niet gegaan het.

Gedurende die later vyftiger jare begin die Mediese Vereniging belangstel in sy eie mediese versekeringskema vir siekteversekering, en met dié doel voor oë is daar ook 'n persoon oorsee gestuur vir studie van die skema in Kanada. Intussen het groot bestaande versekeringskemas op groot skaal siekteversekering verkoop, en in 1959 is die skema vir siekteversekering van die Mediese Vereniging van Suid-Afrika ook op die Rand geloods.

Daar was onmiddellik probleme, soos met enige nuwe skema. Probleme het ontstaan oor tariewe van uitbetaling, metodes van uitbetaling en wie en wat aan die skemas mag behoort. Die treffende saak in verband met die hele aangeleentheid van versekeringskemas is dat nieteenstaande die murmurering, elke geneesheer nog 'n halwe eier bo 'n leë dop verkies. In hierdie saak dan, is daar 'n paar feite wat ons moet onthou:

1. Die skemas behels die oorgrote persentasie van die meeste praktyke.

2. Die skemas voorsien in die behoeftes van talle gevalle wat andersins nooit sou of kon betaal het vir hulle mediese dienste nie.

3. Die skemas trek tog ook wel 'n kleinere aantal gevalle wat normalerwys hoër gelde sou kon betaal het.

4. Die balans tussen (2) en (3) hierbo, is ten gunste van punt (2).

5. Gevolglik is die halwe eier beter as die leë dop.

Laat ons dit dus nou erken en aanvaar dat hulpskemas, van watter aard ook al, gekom het om te bly, en die enigste manier waarop ons onsself kan help is om die skemas te ken en redelik te behandel om sodoende die agting en samewerking van die lede en organiseerders te behou. In hierdie saak moet ons erken dat die skemas wel sorg dat die dokter besoldig word vir 'n baie groot persentasie werk wat andersins gratis verrig sou moes word.

Die Onderlinge Verhouding tussen Praktisyns

'n Korte 40 jaar gelede was hier in Suid-Afrika geen spesialiste soos ons hulle vandag ken nie. Mediese dienste is gelewer deur 'n groep geneeshere wat primêr diens aan die medemens as hulle doel in die lewe gehad het. Deur goeie diens te lewer het hulle ook 'n goeie inkomste gehad. Voeg daarby die sosiale status wat die dokter geniet het, en daar het jy 'n beroep wat werklik deur alle ander professies beny was. Die gevolg was dat talle jong manne die mediese professie as hulle lewenstaak gekies het.

Nou vind ons dat sekere van die ouere kollegas geleidelik meer begin belangstel in verskillende rigtings in die medisyne, dat hulle meer bevoegd raak in spesiale metodes van behandeling, dat hulle oorsee verder studeer en hulle toelê op die spesiale rigting wat hulle kies, en dat hulle dan hulle praktyk beperk tot daardie onder-afdeling en hulle onttrek aan die algemene praktyk; dat hulle dus bloot konsulterende werk doen. Baie gou het hierdie beroemde baanbrekers op die gebied van spesialisasie geweldige praktyke opgebou omdat alle gevalle wat buitengewoon was na hulle verwys is. Dink by voorbeeld aan die name soos I. P. Schabort, Christo Beyers, Charles Saint, en andere.

* Afskeidsrede deur die President gelewer te Kroonstad op 27 Februarie 1960.

Maar soos dit gewoonlik in die lewe gaan, strewe ons almal steeds na hoër en meer en beter, en baie gou het daardie verhewe posisie van sulke uitstaande manne die doel en strewe van elke mediese student en jong gekwalifiseerde geneesheer geword, sodat ons van die middel dertiger jare af 'n stormloop vind om so gou moontlik daardie verhewe sport te bereik. Die lang pad van kwalifiseer—algemene praktyk—en in die rypheid van ondervinding spesialiseer, is vergeet, en die stormloop om 'n hoër graad as M.B., B.Ch. was aan die orde van die dag om dan so gou moontlik die bordjie in Lister-gebou as spesialis te kon ophang. So erg was die toeloop dat 'n statutêre register van spesialiste ingestel moes word. Aanvanklik het dit nog goed gegaan want die verhouding van spesialiste tot algemene praktisyns was in die regte verhouding: daar was genoeg algemene praktisyns om die sifwerk te doen en te sorg dat elke spesialis genoeg gevalle sien om hom besig en goed aan die lewe te hou.

Na die beëindiging van die Tweede Wêreldoorlog het 'n groot aantal spesialiste skielik op Suid-Afrika toegesak. Nie alleen Suid-Afrikaners wat gespesialiseer het nie, maar ook talle uit ander dele van die wêreld het hulle hier kom vestig. Baie van die spesialiste was nie alleen goed gekwalifiseer nie, maar ook goed onderleg en het reeds goeie ondervinding opgedoen. Tans is hulle vinnig besig om die boonste range van medisyne in Suid-Afrika te vul. 'n Hele aantal was egter nie heeltemal so goed soos die titel en benaming voorstel nie, en die eretitel 'spesialoid' is aan hulle gegee. Die belangrike saak is egter dat die verhouding tussen spesialis en algemene praktisyn nou uit verband geraak het.

Omdat sommige spesialiste nie meer 'n redelike bestaan in die stede kon maak nie, het hulle na die buitesentrums begin gaan waar fasiliteite beskikbaar is en het hulle hulle dienste aan die publiek naby die huis beskikbaar gestel. Hierdie ontwikkeling voorsien nie net in 'n behoefte op die platteland nie, maar verseker ook vir die meerderheid van daardie spesialiste 'n goeie inkomste. Dit het egter die toestand van baie stedelike spesialiste kritiek gemaak. Waar die redelike verhouding van spesialiste tot algemene praktisyns op 1 : 12 gestel word, het die spesialiste op plattelandse dorpe die verhouding op hulleself gekonsentreer tot in sommige gevalle 1 : 15 en 1 : 20, terwyl die stedelinge gesny is in sommige gevalle tot 1 : 2, wat in werklikheid 'n belaglike syfer is.

Wat is die gevolg? Om die wolf van die deur te hou, het wanpraktyke begin:

1. Spesialiste tree as algemene praktisyns op tot diè mate dat in sommige gevalle selfs gewone versekeringsondersoeke deur spesialis-chirurge gedoen word.
2. Die publiek word uitgebuit.
3. Hulpverenigings en bystandsfondse word uitgebuit.
4. Kwade gevoelens tussen kollegas ontwikkel as gevolg van die gevoel van onsekuriteit.

Die oplossing van hierdie probleem lê nie in die hou van 'n spesiale register of die bereiking van 'n akademiese graad nie. Myns insiens is die oplossing daarin geleë dat 'n minimum vereiste van 5 jaar algemene praktyk gestel moet word voordat 'n hoër graad erken word as kwalifikasie vir spesialisasie. Daardie 5 jaar is die minimum tyd wat vir enige geneesheer nodig is om sy balans in die beoefening van die beroep van geneeskunde te kry.

Die Individuele Praktisyn

Ten slotte trek ek die kring bietjie nouer om na onsself as individuele mediese praktisyns te kyk—of ons nou ook al spesialiste, algemene parktisyns, of deeltydse of voltydse beamptes van 'n inrigting of organisasie is. Onwillekeurig kom die vraag, wat is die doel van die geneesheer? Met ander woorde, wat is elkeen van ons se doel in die lewe?

Om diè groot vraag te kan beantwoord is dit weer nodig dat ons onsself in perspektief probeer sien. Onmiddellik doem die volgende feite dan op wat van toepassing is op elke geneesheer:

1. Hy is lid van 'n gemeenskap.
2. Hy is 'n bevoorregte lid van die gemeenskap deurdat hy die geleentheid gehad het vir spesiale studie.
3. Hy is verstandelik beter ontwikkel as die gemiddelde lid van die gemeenskap.
4. Hy het daagliks te doen met die intiemste geheime van individue in die gemeenskap.
5. Daar word na hom opgesien as 'n leier en raadgewer in die gemeenskap.
6. Hy word dikwels geraadpleeg oor moeilikhede van individue in die gemeenskap.

Die gevolg hiervan is dat die dokter 'n 'plig' het teenoor die gemeenskap. Sy plig is in die eerste instansie om lyding te versag en die sieke te versorg. Daarbenewens is dit sy plig om as lid van die gemeenskap in balans met die gemeenskap te lewe; hy moet dus ook sy kennis en verstand en kragte beskikbaar stel vir die hele organisasie van die samelewing.

Dit is dus noodsaaklik dat enige geneesheer wat sy sout werd is, daardie hoofdoel van *diens aan sy medemens* sal nastreef, en dit nie alleen wat die mediese praktyk betref nie, want vir daardie diens word hy op een of ander wyse vergoed. Deur onbaatsugtige diens te lewer in sfere van die samelewing buite die mediese praktyk, word sy perskpektief verwyd, en kry hy die nodige afleiding om sy balans te hou. Ook raak hy soms in probleme gewikkel waar hy as mens die smarte van sy medemens aanvoel. Waar ons in 'n wêreld lewe wat primêr materialisties ingestel is, is dit ons plig om die balans te help hou en nie tot so 'n mate meegesleur te word deur die verleiding van weelde dat ons primêre doel in die lewe 'n parasitiese gejaag na geld word wat die motief van diens verdring nie.

Mag ons in die jaar wat voorlê almal gelukkig wees in ons werk en voorspoedig in wat ons onderneem. Mag ons in kalmte van gees onder alle omstandighede ons beste lewer in diens van ons medemens op alle terreine van die lewe. En mag die volgende versugting vir elkeen van ons toebedeel word:

'God grant me the serenity to accept
The things I cannot change,
The courage to change what I can,
And the wisdom to know the difference.'

SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL : SUID-AFRIKAANSE GENEESKUNDIGE EN TANDHEELKUNDIGE RAAD

The 71st meeting of the South African Medical and Dental Council was held in the Council Chamber, Cape Town Chamber of Commerce, Barclay's Bank Building, Adderley Street, Cape Town, on 21 - 26 March 1960. The proceedings occupied 9 half-day sessions. Thirty members were present, including the President (Prof. S. F. Oosthuizen) in the chair, the Vice-president (Prof. H. W. Snyman), and the Treasurer (Dr. R. V. Bird), together with the Registrar (Mr. W. H. Barnard) and staff.

REGISTRATION

The Registrar reported on registrations effected during 1959, as follows:

	Registrations	*Restorations*	*Erasures*	*On Register end of 1959*
Medical practitioners ..	313	34	108	7,788
Interns	260	—	259	416
Dentists	49	9	30	1,316
Medical students ..	337	11	330	1,371
Dental students ..	45	1	56	181
Auxiliaries	236	—	—	1,254
Specialists (medical) ..	85	4	17	1,505
Specialists (dental	—	—	—	18

Of the medical practitioners on the register at the end of 1959, 71·7% had qualified in South Africa (Cape Town 2,461, Witwatersrand 2,394, Pretoria 836, Natal 21), 12·1% in England, 9·4% in Scotland, 3·6% in Ireland, and 3·3% elsewhere.

Of the medical students on the register in 1959 (including 252 who qualified in June and December 1959) 494 were at the University of the Witwatersrand, 492 at Cape Town, 406 at Pretoria, 129 at Natal, and 102 at Stellenbosch.

The specialists on the register at the end of 1959 were as follows (the figures in brackets represent the net increase since the beginning of the year): Medicine 200 (9), surgery 194 (15), radiology 78 (3), radiology and electrotherapeutics 34 (--1), diagnostic radiology 43 (5), therapeutic radiology 5 (0), obstetrics and gynaecology 148 (10), anaesthetics 141 (7), ophthalmology 101 (0), pathology 89 (5), paediatrics 79 (7), orthopaedics 73 (5), otorhinolaryngology 71 (2), psychiatry 79 (7), urology 38 (1), dermatology 32 (1), neurology 31 (0), thoracic surgery 20 (1), neurosurgery

18 (0), venereology 18 (1), physical medicine 14 (−1), plastic and maxillofacial surgery 8 (1). Dental specialists: Orthodontia 10 (0), maxillofacial and oral surgery 8 (0). Forty medical practitioners were registered in two associated specialities, viz. dermatology and venereology 11, neurology and psychology 27, ophthalmology and otorhinolaryngology 1, physiology and radiology-and-electrotherapeutics 1.

The auxiliaries on the register at the end of 1959 were as follows: Physiotherapists 451 (31), masseurs 153 (3), radiographers—diagnostic 96 (70*), radiographers—therapeutic 67 (67*), medical technologists 156 (32), occupational therapists 77 (12), health inspectors 51 (0), orthopaedic mechanics and surgical-appliance makers 50 (4), food inspectors 45 (0), speech therapists 44 (10), chiropodists 36 (2), psychologists 14 (4†), psychometrists 2 (1), dietitians 8 (0), orthoptists 3 (0), optometrists 1 (0).

Registration: Decisions taken at Present Meeting

Limited registration. One new application for registration as a missionary medical practitioner was granted, and 5 registrations were renewed for a further period of 5 years. Two applications were received for a variation of the terms on which missionary registration had been granted, and were refused. An application was also granted, with limited rights of practice, for registration of a medical practitioner to be appointed on the staff of the S.A. Institute for Medical Research and seconded to the Bureau for the Prevention of Blindness of the S.A. National Council for the Blind to supply professional services in connection with the prevention of trachoma amongst Natives.

Exemption from registration. Exemption under section 74(*b*) of the Act was recommended to the Minister for varying periods of months for 5 medical practitioners from abroad on the application of the Universities of Cape Town, Witwatersrand, Pretoria, and Stellenbosch, and the College of Physicians, Surgeons and Gynaecologists of South Africa.

Exemption from annual registration fees. Three elderly medical practitioners were granted exemption from annual registration fees.

Removal from register. Erasures at own request: 13 medical practitioners and 2 dentists. For failure to notify present address: 8 medical practitioners and 2 dentists. Out of a total of about 9,000 medical practitioners and dentists on the register as at 1 July 1959, 30 were erased for failure to pay the annual fee (0·33%).

Reciprocity with the Netherlands. The Council fixed the quota of medical practitioners from the Netherlands registrable in 1961 at 12, as in previous years.

New registrable qualifications. The degree of M.B., B.S. of the University of Karachi was recognized as a qualification registrable under Section 23 of the Act. The Diploma in Industrial Health (D.I.H.) of the University of the Witwatersrand was recognized as a registrable additional qualification.

Registration of specialities. Of applications for the registration of specialities, 23 were granted and 36 were accepted for registration subject to compliance with specified requirements; 27 other cases were reported in which decisions or advice had been communicated to applicants: consideration of 1 application was deferred. Various institutions or departments of institutions, and posts therein, were recognized as acceptable for the requirements of the rules for the registration of specialities.

Registration of auxiliaries. Applications for registration were dealt with as follows: Chiropodist 2 (both refused), diagnostic radiographer 3 (all refused), physiotherapist or masseur 4 (2 granted as masseur, 1 refused, 1 deferred), medical techologists 15 (13 granted, 1 refused, 1 deferred), orthopaedic mechanician and surgical-instrument maker 3 (all granted), psychologist 3 (2 granted, 1 refused), psychometrist 1 (granted).

Failure to register on completion of internship. An ex-intern, whose internship was completed at the end of 1957, then without registering as a medical practitioner worked in salaried positions first as a senior houseman until the end of 1958 and then as registrar. He registered in August 1959 and now finds himself in difficulties about his salary and about 'time' which, had he been registered, might have counted towards the requirements for specialization. He now applies for his registration to be ante-dated to the time when his internship was completed. The Council decided to refuse this application.

* Including registered radiographers transferred to registers for diagnostic radiographers and therapeutic radiographers.
† Adjusted figure.

Change of name in register. When a registered practitioner whose name has been lawfully changed applies to have his 'new' name entered in the register the practice hitherto has been to create an entry consisting of the 'new' name together with a reference to the existing entry under the 'old' name, where the address, qualifications, etc. are to be found. A medical practitioner whose name was changed over 30 years ago has called this practice in question, and has asked that in future his entry shall appear under his present name only. The Council has given consideration to the general question and has now ruled that if a practitioner's name has been lawfully changed and he is legally entitled to assume the 'new' name which he desires to substitute for his 'old' name in the register (or under which he wishes to be registered), the 'new' name shall be entered in the register without reference to the 'old' name, a record of the change being made in the file which is kept by the Registrar of the practitioner concerned. This, however, is subject to the applicant's producing proof that he has notified his change of name to the university or licensing body from whom he obtained his qualifications. Such lawful change of name takes place, *inter alia*, with the consent of the Governor General under Section 9 of Act 1 of 1937, or when a woman practitioner marries.

Change of additional qualification in register. The Council also decided that where an additional qualification has been registered and has been subsequently altered owing to change of name of the body that granted it, a corresponding alteration may be made in the register at the request of the practitioner concerned. Thus when the College of Obstetricians and Gynaecologists assumed the name of 'Royal College' the original F.C.O.G. became F.R.C.O.G.; and a practitioner in whose name F.C.O.G. is registered may have it altered to F.R.C.O.G.

Rules for Registration of Medical Technologists

At its previous meeting (September 1959) the Council, having received the rules as approved by the Executive Committee, directed them to be submitted to a special committee consisting of the President and 2 other members of the Council and 2 representatives each of the Medical Association and the Society of Medical Laboratory Technologists, and that the rules with the recommendations of this special committee should then come before the Executive Committee 'to finalize, with power to act'. The Executive Committee made final amendments and submitted the rules to the Minister for approval and promulgation, and the rules have since been promulgated. The Medical Association has now addressed to the Council a letter dated 15 March 1960 asking that certain amendments should be made in the rules in accordance with suggestions previously submitted by the Council, and that alternatively the letter should be sent to the Minister without delay for his consideration. However, as the rules had already been promulgated, the Council referred the letter to a standing Committee for consideration.

REGISTRATION OF OPTOMETRISTS

As a compromise had been reached in this matter between the Medical Association of S.A. and the S.A. Optical Association,[1] the Council now referred the drafting of the necessary rules to the Executive Committee and, in order to assist the Executive Committee, decided to appoint an *ad hoc* committee consisting of members of the Council, the Medical Association and the S.A. Optical Association to do the preliminary work and draft rules regarding the conditions under which registered optometrists may carry on their calling. In view of the urgency of the matter the Executive Committee resolved that the *ad hoc* committee should report direct to the present meeting of the Council. The Council now had before it the report of the *ad hoc* committee, which had met on two occasions, with Professor Oosthuizen in the chair. The findings of the committee are summed up in the draft rules which were embodied in the report. These rules may be summarized as follows:

The registered optometrist is not to supply glasses to any person in whom a pathological condition should be suspected (unless previously referred by a doctor to the optometrist as suffering from a chronic unchanging condition) or to children under 8 years old, but shall refer such cases to a medical practitioner; this, however, does not apply to the repair or replacement of prescribed glasses. Nor shall he apply drugs or surgery in examining any person.

As regards advertisement, for 5 years after the rules have been promulgated the registered optometrist will be at liberty to use

display windows, and luminous signs containing only his name and occupation, at the premises where he (or a registered optometrist) regularly attends, and to advertise in the lay press by a business-card advertisement not containing more than his name, occupation, qualifications, address, telephone number, and consulting hours.

Otherwise the registered optometrist (like other registered auxiliaries) may not advertise himself directly or indirectly; nor allow the publication of any matter which draws attention to him professionally or deprecates the knowledge, skill, etc. of any other registered person; nor advertise his qualifications at any rooms where he (or a registered optometrist) does not regularly attend; nor solicit business from house to house or employ hawkers or canvassers; nor advertise in such a way as to reflect discredit on his profession, or lead the public to believe he is a medical practitioner or an ophthalmic specialist.

He may, however, advertise in recognized medical and technical papers; affix a doorplate of 14 × 8 inches at his residence or rooms showing his name and qualifications; and call upon, circularize or write to doctors, medical institutions or hospitals.

A penalty of £10 is provided for contravention of these rules.

Dr. A. W. S. Sichel said that, although the Ophthalmological Society, previously against the policy of registration, had now adopted it, many ophthalmologists were strongly opposed. If the compromise were not adopted there were two alternatives: (1) The present condition, with no control, would continue, which was most undesirable, or (2) the opticians would try for a charter. Medicine, in fact, was at the cross-roads. The one thing in common between the two parties (and the Council) was the desire for a *compulsory* register. Optometrists were not really medical auxiliaries and, when compulsory registration comes, the control should be vested in a joint board, and this would overcome most difficulties.

The Council adopted the draft rules as submitted by the *ad hoc* committee for approval and promulgation by the Minister.

MEDICAL EDUCATION

Planning and Siting of Teaching Hospitals

At its meeting in September 1959 the Council had decided to call a conference 'with a view to establishing a policy with regard to the planning and siting of hospitals for White and non-White patients acceptable to the departments and bodies concerned in order to ensure adequate clinical facilities for teaching bodies; the conference to consist of representatives of (1) the universities with medical faculties, (2) the State departments of Health, Education, Bantu Education, Bantu Administration and Development, and Coloured Affairs, (3) the provincial administrations, and (4) the S.A. Medical and Dental Council.

The conference was held in Pretoria on 10 February 1960, Professor Snyman in the chair, and a report of the meeting was now before the Council. It recorded that the conference had noted:

1. The necessity that a sufficient number and variety of White and non-White patients should be available for the purpose of clinical training, and that clinical training must be retained or made available on geographical units.

2. The attitude of the provincial authorities, who were unable to comply with the requirements under (1) within the framework of national policy.

3. The stated policy of the Government with regard to the transfer of all Bantu patients to specific hospitals in the Bantu areas.

It was the considered opinion of the conference that in order to provide for the requirements under (1) it would be necessary to allocate a specified number of non-White patients to the teaching hospitals; and that, in the future erection of teaching hospitals, these requirements could most easily be satisfied by locating them on the border of group areas. It would therefore seem that special financial provisions would have to be made for the universities and provincial administrations concerned, so that the dictates of necessity and policy could both be satisfied.

The conference recommended that a deputation from the Council, through the responsible Minister, should ask to be received by all the Ministers concerned in this problem, for elucidation and discussion. The recommendation was accepted by the Council.

Internship in Hospitals in African Territories

A report was before the Council by Professor Snyman, who on behalf of the Council had inspected various hospitals in Africa outside the Union, and the Council decided to recognize the following hospitals for the purpose of the regulations relating to interns:

Southern Rhodesia: The Group of Central Hospitals, Bulawayo; the Group of Central Hospitals, Salisbury; the General Hospital, Umtali.

Northern Rhodesia: Central Hospital, Lusaka; Llewellyn Central Hospital, Kitwe.

Nyasaland: Queen Elizabeth Central Hospital, Blantyre.

Belgian Congo: Hôpital des Congolais, Leopoldville; Hôpital Prince Leopold, Elizabethville; Bukavu Hospital; Luluaburg Hospital; Stanleyville Hospital; Usumbura Hospital.

Uganda: Unlago Hospital, Kampala.

Kenya: King George VI Hospital, Nairobi.

Nigeria: University College Hospital, Ibadan.

Senegal: Hôpital de Dantee, Dakar.

Applications for the approval of internship at other hospitals in African territories will be considered on their merits; full information regarding the hospital must be submitted.

The Council also decided to recognize internships served in hospitals listed in the Directory of Approved Internships and Residencies of the American Medical Association.

Other applications for the approval of internships were granted.

Nomenclature and Certification of Posts in Teaching Hospitals

A conference on this subject was held in Johannesburg on 20 January 1960 under the chairmanship of Professor Oosthuizen, representatives being present of the Council, the Medical Association, the provincial Directors of Hospital Services, and the universities with medical faculties. The report of the conference was now before the Council.

The conference recorded that it favoured the system in vogue in the Transvaal provincial administration, and recommended the Council to suggest to the other provincial administrations that they should adopt that system. This recommendation was adopted by the Council.

Hypnosis

This matter again came under consideration and the Council decided not to specifically include hypnosis in the minimum curricula for medical and dental students. Such teaching, in the discretion of individual universities, is not precluded by the existing regulations.

ETHICAL RULES AND RULES CONCERNING SPECIALISTS

Embodiment in the Ethical Rules of the New Rules on the Conditions under which Specialists may Practise

The Executive Committee submitted a memorandum by the President on this subject, which it had considered, and recommended the deletion of the present rule 13 (concerning consultants and specialists) of the Council's ethical rules and the substitution for it of the following new rule:

13. Consultants and Specialists

(1) The commission of acts prohibited or the omission of acts prescribed in the rules promulgated under paragraph (*r*) of subsection (2) of section 94 of . . . (Act No. 13 of 1928) as amended.

(2) Holding himself out as a consultant when attending and treating patients except in consultation with and at the request of other practitioners.

The Executive Committee also recommended the insertion of a new rule (14*bis*) in the ethical rules as follows:

14*bis*. Improperly impeding a patient (or a person properly acting on behalf of a patient) who desires to obtain the opinion of or treatment by another practitioner.

The proposed rules 13 and 14*bis* were approved by the Council for submission to the Minister for his approval and promulgation.

Ethical Rule 21 (3): *Consulting Rooms*

The existing rule is as follows: '(3) Using in connection with his consulting rooms the term hospital, clinic or any other similar name, which might lead the public to believe that the consulting rooms are part of a hospital, clinic, nursing home or other similar institution or have features differing from those of ordinary consulting rooms'.

In September 1958 the Council had this rule under consideration 'in its widest implications' and particularly whether to add to the rule the words 'except in so far as the terms of his employment are

such as reasonably to preclude the use of any other address'. The matter had then been referred to the Federal Council of the Medical Association, who in 1959 resolved to ask that rule 21(3) should be retained. The Medical Association was then again asked for its opinion in the light of the suggested specific addition, and again the Federal Council (in March 1960) resolved that the rule should be retained without change.

After considerable debate, during which it was pointed out that the rule deals only with the name or address used in connection with consulting rooms, the Council resolved to make no change in rule 21(3).

Designation of Specialists

In the Council's ethical rules and in its rules for the registration of specialities the word 'specialist' appears before the name of each speciality; thus, 'specialist anaesthetist', 'specialist orthopaedist'. Prof. H. W. Snyman moved, for all specialities, the deletion of the word 'specialist' wherever it appears in the designation of a speciality. The proposal was passed. (In the course of the debate it was mentioned that there were substantial rulings of the Council allowing the use by general practitioners of the time-honoured name 'physician and surgeon'.)

Rules 19 and 19bis: Advertising of Professional Appointments

By reason of recent amendments passed by the Council (subject to approval and promulgation by the Minister) under both rule 19 and rule 19*bis* the list of acts or omissions of which the Council may take cognizance includes the acceptance of a professional appointment unless it has been advertised in 'the South African Medical Journal' or 'the Journal of the Dental Association of South Africa'. A motion was proposed that in each rule these words should be deleted and the words 'a South African medical journal' and 'a South African dental journal' substituted. After debate the motion was lost.

Disclosure of Diagnosis to Medical Aid Society

In reply to an enquiry about the ethical position when a doctor is asked to disclose to a benefit society the specific diagnosis in a patient's illness, the Council informed the Medical Association (Cape Midland Branch) as follows:

(*a*) A medical certificate to a third person shall not ordinarily disclose a diagnosis.

(*b*) A medical certificate disclosing a diagnosis may be given to a patient provided the full implications of the certificate have been explained to the patient.

(*c*) Any medical certificate or report may be handed to a third person with the written consent of the patient; the consent to be obtained at the time when the certificate is issued.

Consents and authorizations not signed at the time of the request for a certificate should not be considered binding on the practitioner from whom the certificate is requested; similarly, where the practitioner is of opinion that the patient may have signed a consent under duress or misapprehension, he should exercise his discretion and judgment before disclosing information concerning the patient to a third party.

Reference of Patient to a Particular Optometrist

On consideration of an enquiry on the subject, the Council recorded that, while it regards it as undesirable for prescriptions to be referred to a particular optometrist as a matter of routine, it might be necessary for this to be done in certain special circumstances in the interests of the patient; in the event, however, of a complaint being lodged against the practitioner he might be called upon by the Council to justify his action.

The Council expressed the opinion that an ophthalmologist had the right to require the submission to him for inspection of spectacles made to his prescription.

THE PROFESSION AND THE PRESS

Several motions were before the Council on the publication of medical matters in the press, and considerable debate ensued.

Dr. R. L. Impey called attention to personal notices about practitioners that are published in the medical press, especially those containing details of courses of study or other work overseas undertaken by the doctor mentioned in the notice. The Council resolved to invite the cooperation of the medical press in refraining from publishing personal notices that might be looked upon as advertisements. Prof. I. Gordon said there was a growing practice in the lay press of mentioning doctors' names when taking over matter printed in the medical journals. He suggested that medical journals should be requested to publish a standing request asking that the names of contributors should not be mentioned in the lay press.

A debate also took place on the disposition recently shown by some hospitals, universities and other medical groups to try to aggrandize their achievements in the eyes of the public. 'Medical marvels' were boosted in the press and on the radio and television. Dr. A. Radford referred to an article, illustrated with photographs taken in the operating theatre, which had recently appeared in a newspaper on an open-heart operation in a university hospital. He remarked that, apart from the advertisement aspect, it could hardly be in the interest of the patient to introduce a press photographer during such an operation. Doctors' names were not mentioned in this kind of article, but generally it was not difficult to identify the doctors. Though the object might be to raise funds for a medical institution, or even to enlighten the public, yet this kind of advertising was degrading to the profession. Doctors were responsible for their own actions and they could not shelter themselves behind a hospital or university that was running an advertising campaign. Dr. Impey said that in England and America a strong reaction had developed against such advertising on the part of organized medicine, which, as Prof. J. Howard Means had said, 'should abide corporately by its code of ethics as assiduously as it expects its individual members to do'.

Dr. J. K. Bremer called attention to the large number of misleading or false reports and articles about diseases, particularly cancer, which appeared in the public press. In many cases truth seemed to be quite a secondary consideration. The Council expressed its concern over this, and decided to direct the attention of the Newspaper Press Union to the serious consequences that may result and to seek the cooperation of the Union in order to ensure correct reporting on health matters. It was also suggested that Branches and Divisions of the Medical Association should appoint persons with whom the Press could consult for this purpose. Prof. G. A. Elliott said his experience was that the press was most anxious to ensure scientific accuracy in its articles and would welcome cooperation on the part of the Association. We as a profession, he said, are much to blame and if we do not cooperate the press will proceed without us.

ADEQUACY OF MEDICAL AND DENTAL TREATMENT

Commission of Enquiry into High Cost of Medical Services

The President reported that he had received a letter on this matter from the Minister of Health, and that he had informed the Minister that the Council, if invited, would be prepared to tender evidence before the Commission. The Council concurred.

In this connection debate took place on the subject of the adequacy (in numbers and distribution) of doctors and dentists in South Africa. Many aspects of the problem were discussed, but most of the speakers agreed that, while the present number of doctors and dentists and the annual output of the medical and dental schools were quite insufficient for the needs of the population of all races, yet it was doubtful whether present economics would enable many more to be absorbed into private practice. In 1948 an investigation made in the Council's office showed that in Johannesburg there was 1 doctor to 450 of the European population, while in Zululand and the Northern Transvaal 1 doctor was serving a population of 50,000 - 70,000. From the difficulty experienced in filling posts and obtaining locums in private practice it appeared that there was today a shortage of general practitioners. But there were plenty of applicants for specialist posts. Last year the number of specialists registered was more than a quarter of the number of new registrations of practitioners.

Dr. H. Grant-Whyte moved that the Executive Committee of the Council should undertake an investigation into maldistribution of doctors and dentists and should offer guidance to the Minister of Health (through the Commission of Enquiry) on ways and means of providing an adequate medical service for the whole population. Speakers questioned whether this would properly fall within the Council's functions, and the motion was lost. The President said that this decision did not detract from the Council's offer to submit evidence to the Commission.

Availability of the Benefits of Modern Surgery

At its previous meeting[1] (September 1959) the Council referred for consideration by its Executive Committee Dr. Impey's motion

to appoint a fact-finding committee to enquire 'whether the manifold benefits of first-class modern surgery were generally available to the public of South Africa'. The Executive Committee, after considering a memorandum by Dr. Impey, now reported that the provincial authorities were anxious to cooperate and had agreed to supply information about surgery in their hospitals; and on the recommendation of the Committee the fact-finding committee was appointed, consisting of Dr. Impey, Dr. Bremer and Dr. P. F. H. Wagner.

Facilities for Treatment of Mental Ill-health

A discussion took place in continuation of those at the previous meetings.[1] A subcommittee consisting of Professor Snyman and Professor Elliot submitted a report on their investigation into existing facilities for training in psychiatry at South African medical schools, and on consideration of this report the following conclusions were drawn:

1. That facilities for undergraduate and postgraduate teaching in psychological medicine and the cure of patients suffering from disorders in this field were inadequate.
2. That teaching in this field and the attendance of patients could not be separated from internal medicine.
3. That such teaching and attendance (especially in non-certifiable patients) should be closely integrated with the teaching of, and attendance of patients in, internal medicine, particularly in provincial hospitals.

The Council resolved to advise the Minister, in the interest both of the public and of the undergraduate and postgraduate student, to institute consultation with the provinces and universities in an attempt to remove difficulties under the above 3 headings; and to inform the Minister of the Council's policy of recognizing work done by interns in mental hospitals.

DISCIPLINARY

The following cases were reported as having been dealt with under the disciplinary powers of the Council since the last meeting:

In 19 cases (18 medical practitioners and 1 dentist) complaints against practitioners had been made to the Council. Of these, 17 (including the case of the dentist) were dealt with by the Executive Committee without a formal enquiry, and in 2 cases an informal interview had been arranged with the doctor concerned.

One other case concerned the anaesthetist at an operation in which the patient died on the operating table. He was charged with culpable homicide in the magistrate's court, and was found not guilty and discharged. On the facts the Executive Committee decided to take no action.

In another case concerning an anaesthetist, an inquest had been held on a patient who died after operation. In this case the Executive Committee ordered an enquiry by a special disciplinary committee.

One other case was referred for a formal enquiry to be held before the Executive Committee. This had reference to a doctor who had been convicted in the magistrate's court of driving a motor vehicle under the influence of liquor.

The result of an enquiry which had been heard by the Executive Committee was reported. It concerned a doctor (Dr. J.A.H.) who had been convicted in the magistrate's court of defrauding the Union Health Department of the sum of £59 9s. 0d. and had been fined and ordered to refund that amount. He was found guilty of improper conduct, and reprimanded and cautioned.

The registrar of a university reported that the university has suspended 2 medical students for 2 years for unseemly conduct. The facts were noted.

Cases of Alleged Overcharging (Section 80bis)

In 3 cases assessors were appointed, and in 1 case the report of assessors was received, considered and noted (all concerning medical practitioners). Complaints or enquiries had been received in 18 cases (14 doctors and 4 dentists) in which there appeared to be no ethical implications, and the persons who wrote were advised of the procedure prescribed under section 80*bis* of the Act.

Simplification of Procedure under Section 80bis

Mr. W. H. Rood proposed the appointment of an *ad hoc* committee to investigate and make proposals with a view to possible simplification of the cumbersome procedure that has to be followed by persons applying to the Council for the assessment of practitioners' accounts. He said the procedure discouraged people who had genuine grievances from taking advantage of the section. After discussion the motion was accepted and a committee consisting of Dr. B. de Villiers, Dr. J. v.d. S. de Villiers and Adv. v.W. de Vries was appointed.

MISCELLANEOUS

Benefit-society doctor sharing work with assistant or partner. Dr. Bremer submitted a motion that a medical practitioner appointed to a part-time post should himself carry out the duties attached to the appointment, provided that in emergency or during reasonable off-duty times, holidays or sick leave he may allocate the duties to another practitioner; whereas Dr. L. O. Vercueil moved that holders of benefit-society appointments may employ assistants but that they should in normal circumstances do the bulk of the work themselves. Furthermore, the Medical Association (Cape Western Branch) had made an enquiry of the Council on the subject. After debate the Council referred the matter to the Executive Committee for further consideration, Drs. Bremer and Vercueil being invited to submit memoranda. The Committee was empowered to consult with the Medical Association.

Radio-active isotopes. On consideration of an enquiry the Council ruled that no. 13 ('consultants and specialists') of the ethical rules does not preclude a specialist physician from administering radio-active isotopes therapeutically, provided he does not make an extra charge for the procedure and provided the provisions of rule 25 (re inadequate training or experience) are not contravened. Whether the Atomic Energy Board would be prepared to authorize him to use radio-active isotopes is not a matter within the purview of the Council.

Finance. The Treasurer (Dr. R. V. Bird) presented the Council's audited accounts for 1959. The receipts exceeded the expenditure by £3,366, which was added to the accumulated funds. The invested funds of the Council at 31 December 1959 amounted to £31,158, plus £4,411 on savings account. Of the total income of £37,182 in 1959, £26,694 was from annual fees of registered persons and £8,580 from registration fees, of which £7,208 was paid by medical practitioners and specialists, interns and medical students.

Retirement of Dr. du Pré le Roux. The President called attention to the pending retirement of Dr. le Roux from his position as Secretary for Health, and said that this might be the last meeting of the Council Dr. le Roux would attend. He was beloved by all those with whom he had worked. He had been a tower of strength to the Council, and Professor Oosthuizen moved that the Council expressed its sincere thanks and appreciation to Dr. le Roux for his contribution over many years and its very best wishes for the future. Carried unanimously.

Appreciation. The Executive Committee resolved that the Committee's appreciation be recorded of the full report in the *South African Medical Journal*[1] on the business transacted at the meeting of the Council in September 1959. This resolution was reported to the Council and adopted.

Next meeting of Council. It was decided to hold the next meeting in Johannesburg, commencing on 12 September 1960.

1. South African Medical and Dental Council, Report (1959): S. Afr. Med. J. 33, 948.

JOHNSON & JOHNSON AWARDS FOR POSTGRADUATE CLINICAL STUDY IN SOUTH AFRICA

These awards have been established by a grant from Johnson & Johnson (Pty.) Ltd., P.O. Box 727, East London.

The Selection Committee (an entirely independent board of medical practitioners) consists of the following:

Prof. S. F. Oosthuizen (Pretoria) Chairman; Dr. P. F. H. Wagner (East London) Vice-Chairman; Dr. H. A. Shapiro (Johannesburg) Hon. Secretary; Dr. Beck de Villiers (Bloemfontein); Dr. H. Grant-Whyte (Durban).

Applications are invited from registered *general practitioners* who have been in active practice in South Africa for at least 7 years.

The bursary is intended for postgraduate clinical study and not for medical research. It is available for not less than a 2-month period at any medical school in South Africa.

The total value of each bursary is £200.

The candidate must submit a brief statement of his proposed course of study and indicate the institution at which he intends to undertake it.

No payment will be disbursed to the successful applicant until he has satisfied the Selection Committee that he has been accepted for the period of postgraduate study at a South African medical school.

Applications must be made on the prescribed form which is obtainable from: Dr. H. A. Shapiro (Hon. Secretary), Selection Committee, Johnson & Johnson Awards for Postgraduate Clinical Study, P.O. Box 1010, Johannesburg.

Five Fellowships will be available for award during 1960.

The closing date for applications is 1 August 1960.

MEDICAL ASSOCIATION OF SOUTH AFRICA

AUTHORIZATION : REMOVAL OF HUMAN TISSUE FOR THERAPEUTIC PURPOSES—URGENT CASES

The above matter was discussed by the Parliamentary Committee at a meeting held on 25 January 1960 and the following is an extract from the minutes of this meeting:

'The Assistant Secretary (Transvaal) supplied the following information:

1. The *Post-mortem* Examination and Human Tissue Removal Act requires that authorization for the performance of a *post-mortem* examination or the removal of human tissue from a dead body for scientific and therapeutic purposes must be given by a magistrate of the district in which the person has died, except where such person has died in a public hospital whose Medical Superintendent has been specifically authorized by the Minister to give such authority.

2. Difficulties sometimes arose where patients who had, for instance, donated their eyes, died during the night outside a hospital, because the authority of a magistrate could not be obtained for the removal of the eyes until the next morning. (Unless the eyes are removed within 2 or 3 hours after death, the whole purpose of the donation is frustrated.)

3. As a result of representations made by the Superintendent of the Johannesburg Hospital, the Chief Magistrate of Johannesburg had arranged for a roster of magistrates in the Johannesburg area who would be available after hours to deal with urgent applications for authorization for removal of human tissue for therapeutic purposes.

4. The Superintendent of the Johannesburg Hospital had forwarded the correspondence in connection with the matter to the Southern Transvaal Branch of the Association with a view to the institution of a similar system at other important centres in the Union.

5. The Southern Transvaal Branch had agreed that copies of the correspondence be forwarded to the Parliamentary Committee for consideration.

After full discussion the Committee agreed that copies of the correspondence be sent to all Branches for their information and any action which they may wish to take locally.'

P.O. Box 1521
Pretoria

P. D. Combrink
Assistant Secretary : Transvaal

SOUTH AFRICAN COUNCIL FOR SCIENTIFIC AND INDUSTRIAL RESEARCH

POSTGRADUATE BURSARIES FOR DIRECTED RESEARCH

1. The South African Council for Scientific and Industrial Research is offering a limited number of bursaries for directed research, either at approved overseas institutions or within its own laboratories.

2. The bursaries will be awarded for subjects in the field of the pure and applied sciences (including medicine, dentistry, pharmacy, engineering, architecture and applied psychology), where adequate post-M.Sc. training is not available in universities in the Union of South Africa.

3. The Council will require a high standard of candidates and does not bind itself to make awards.

4. The bursaries for overseas study will be tenable from 1 October 1960, and those for work in the Council's laboratories from 1 January 1961. They will be awarded for 1 year at a time and may be renewed if satisfactory reports are received on the bursar's progress.

5. The maximum value of the bursaries will be:

£400 *per annum* for work in CSIR laboratories.

£600 *per annum* for work in the United Kingdom or the Continent of Europe.

£800 *per annum* for work in the United States of America and Canada.

Application may also be made for a travel grant of not more than £220 for candidates wishing to proceed overseas.

6. Applicants must: (*a*) Submit programmes of research; (*b*) if proceeding overseas, undertake to return to the Union of South Africa for at least 2 years after termination of their bursaries; and (*c*) make their own arrangements for entry into overseas institutions approved by the CSIR.

7. All bursaries will be subject to the Council's regulations governing research awards and applications must be on the Council's application form R.A.1. Forms and copies of the Regulations are obtainable from the Registrars of South African universities or from the Administrative Officer-in-Charge, Medical Research/Research Grants Division, CSIR, P.O. Box 395, Pretoria.

8. Applications should, where possible, be submitted through the registrar of the university to which the applicant is attached. Although it is too late to make application for overseas bursaries for 1960, the closing date for applications for bursaries available in the Council's own laboratories is 31 August 1960.

SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

PUBLICITY

The following is the text of a letter which has been received from the Registrar of the Council:

'I am directed by the South African Medical and Dental Council to draw your attention to the undernoted motion adopted by the Council at its recent 71st Ordinary Meeting, and to request your kind cooperation in the matter. The motion reads as follows:

> "That the Council invite the cooperation of the medical press (*a*) to refrain from publishing personal notices in relation to medical practitioners which may be looked upon as an advertisement; (*b*) to take note of Section 33(3) of the Medical, Dental and Pharmacy Act (as amended), which states 'No registered person shall take, use or publish in any way whatsoever any name, title, description or symbol indicating or calculated to lead persons to infer that he possesses any professional qualification which is not shown in the register in connection with his name'; and (*c*) to publish in the medical journals a standing request that it is desired by the Editor or the Editorial Board, that the names of contributors should not be mentioned in the lay press".

'Your assistance and courtesy in this matter will be highly appreciated'.

WORLD LIST OF INTERNATIONAL MEETINGS

ALTERATIONS AND ADDITIONS NOTIFIED DURING APRIL 1960

Second Asian-Pacific Congress of Cardiology, Melbourne, 30 May - 3 June 1960. Dr. Austin E. Doyle, Hon. Secretary, c/o Alfred Hospital, Melbourne, S.1., Australia.

International Neurological Meeting (Réunion Neurologique Internationale), 24th, Paris 31 May - 1 June 1960. Dr. J. Sigwald, Secrétaire Général, Société Française de Neurologie, 68 boul. de Courcelles, Paris 17e, France.

Commission for Technical Cooperation in Africa South of the Sahara, Specialists' Meeting on the Facilities for the Encouragement of the Use of Radioisotopes in Africa, Leopoldville, Belgian Congo, 31 May - 6 July 1960. Post Box 949, Bukavu, Belgian Congo.

International Symposium on Drugs Affecting Lipid Metabolism, Milan, 2 - 4 June 1960. Prof. S. Garattini, Institute of Pharmacology, University of Milan, Via Andrea del Sarto 21, Milan, Italy.

Society of Physical Chemistry, 10th Annual Meeting, Paris, 7 - 10 June 1960. Prof. G. Emschwiller, Secrétaire Général, Societe de Chimie Physique, 10 rue Vauquelin, Paris 5e, France.

International Commission on Alcoholism, 1st session, Paris, 8 - 10 June 1960. André Bertrand, 24 boul. Raspail, Paris 7e, France. In association with Conference of French Industrial Enterprises on Safety at Work and Alcoholism. Precedes 6th meeting, European Institute of Scientific Studies for the Prevention of Alcoholism, 13 - 24 June.

International Poliomyelitis Congress, Denmark, 26 - 28 July 1960. E. Yuel Hellingsen, Sund hedstyrëlsen, Slotshohnsgade 10, Copenhagen, Denmark.

Food and Agriculture Organization of the United Nations/UN, Children's Fund, Conference on Nutrition Education, Rio de Janiero, July 1960. International Agency Liaison Branch, Office of the Director General, FAO, Viale delle Terme di Caracalla, Rome, Italy.

Food and Agriculture Organization of the United Nations/WHO, Expert Committee on Nutrition, Geneva, July 1960. International Agency Liaison Branch, Office of the Director General, FAO, Viale delle Terme di Caracalla, Rome, Italy.

European Regional Conference on Electron Microscopy, Delft, The Netherlands, 29 August - 3 September 1960. Dr. A. L. Houwink, c/o Laboratorium van Microbiologie, Julianalaan 67 A, Delft, Netherlands.

Symposium on the Initial Effects of Radiation on Living Cells, Moscow, August 1960. Academy of Science of the USSR, Lenin Prospekt, Moscow, USSR. (UNESCO)

Second World Conference of Angiology, Bad Nauheim, Germany, 7 - 10 September 1960. Prof. Dr. Max Ratschow, Conference Chairman, Moserstrasse 1, Darmstadt, Germany.

Scandinavian Society of Neurosurgery, 15th Annual Meeting, Lund, Sweden, 9 - 10 September 1960. Lars Leksell, M.D., Länslasarettet, Lund, Sweden.

Seventh International Congress of Hydatidology, Rome and Sassari, Sardinia, 15 - 19 September 1960. Prof. Luigi Imperati, Secretary General, International Association of Hydatidology, Clinica Chirurgica, Policlinico Umberto 10, Rome, Italy.

Sixth International Convention on Nutrition and Vital Substances, Baden-Baden, Germany, and Strasbourg, 5 - 9 October 1960. International Society for Research on Nutrition and Vital Substances, Bemeroder Strasse 61, Hannover-Kirchrode, Germany.

Symposium on Chemical Effects of Nuclear Transformation, Vienna, 24 - 27 October 1960. International Atomic Energy Agency, 11 Kärtner Ring, Vienna 1, Austria.

French Society of Orthopaedics and Traumatology, 35th Congress, Paris, 3 - 5 November 1960. P. Lance, Secretary, Société Francaise d'Orthopédie et de Traumatologie, 120 boul. Saint-Germain, Paris 6e, France.

Second Latin American Congress of Neurology, 27 November - 1 December 1960. Congress Secretariat, c/o Hospital Rawson, Catedra de Neurologia, Avda. Alcorta 1402, Buenos Aires, Argentina.

Regional Symposium on the Use of Radioisotopes in the Study of Endemic and Tropical Diseases, November - December 1960. International Atomic Energy Agency, 11 Kärnter Ring, Vienna 1, Austria.

IN DIE VERBYGAAN : PASSING EVENTS

Universiteit van Pretoria, Fakulteit Geneeskunde. Die vierde Interdepartementele Bespreking vir 1960 sal Saterdagoggend 21 Mei om 8.30 vm. in die Onderste Lesingsaal, Kliniese-gebou, plaasvind. Die onderwerp vir die bespreking is 'Huidkarsinoom' en dr. G. H. Findlay sal as voorsitter optree. Die sprekers is as volg: Dr. E. J. Schulz (Die premaligne velletsel en sy behandeling), dr. G. H. Findlay (Aspekte van die diagnostiek van huidkarsinoom), dr. C. L. Botha (Die rol van die radioterapeut by die behandeling van velkanker) en dr. Pierre Hugo (Die rol van die plastiese-chirurg by die operatiewe behandeling van huidkarsinoom). Alle medici wat belangstel in hierdie besprekings is welkom.

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South African Institute for Medical Research, Johannesburg, Staff Scientific Meeting. The next meeting will be held on Monday 23 May at 5.10 p.m. in the Institute Lecture Theatre. Dr. H. M. Silk will speak on 'Some aspects of cancer research and cell ultrastructure'.

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University of Cape Town and Association of Surgeons of South Africa (M.A.S.A.) Joint Lectures. The next lecture in this series will be held on Wednesday 18 May at 5.30 p.m. in the E-floor Lecture Theatre, Groote Schuur Hospital, Observatory, Cape. Dr. R. Sealy will speak on 'Radiobiology' and Dr. M. B. Bennett on 'Principles of radiotherapeutic techniques'. All members of the Medical Association are welcome.

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Advertensies vir Kontrakaanstellings. Die aandag van lede van die Vereniging word gevestig op die moontlikheid dat advertensies vir kontrakaanstellings in ander tydskrifte as die *Suid-Afrikaanse Tydskrif vir Geneeskunde* mag verskyn. Wanneer 'n advertensie vir 'n aanstelling wat nie goedgekeur is nie, in die *Suid-Afrikaanse Tydskrif vir Geneeskunde* geplaas word, verskyn daar terselfdertyd 'n aankondiging wat lede aanraai om met die Ere-sekretaris van die betrokke Tak in verbinding te tree alvorens hulle aansoek doen om die betrekking. Wanneer advertensies in ander tydskrifte verskyn is daar geen aanduiding of sodanige aanstellings goedgekeur is of nie. Dit sal daarom tot voordeel van geneeshere wees om van hulle plaaslike Tak te verneem of 'n aanstelling wat in 'n ander tydskrif verskyn het, deur die Vereniging goedgekeur is of nie.

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Mr. S. Robert Shar, F.R.C.S. (Eng.), F.R.C.S. (Edin.), has recently returned to the Union after spending 6½ years doing postgraduate work in various centres in the UK. Mr. Shar has now commenced practice as a surgeon at 230 Lister Building, Jeppe Street, Johannesburg. Telephones: Rooms 22-3822, residence 44-0228, emergency 22-4191.

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Dr. S. Robert Shar, F.R.C.S. (Eng.), F.R.C.S. (Edin.), het onlangs teruggekeer na die Unie nadat hy 6½ jaar lank nagraadse werk gedoen het aan verskeie sentrums in die V.K. Dr. Shar het nou begin praktiseer as 'n chirurg te Lister-gebou 230, Jeppestraat, Johannesburg. Telefone: Spreekkamer 22-3822, woning 44-0228, dringend 22-4191.

* * *

University of the Witwatersrand, Medical Graduates Refresher Course July 1960. The Committee organizing this course have announced that they have, regretfully, been forced to reject applications for this course, since they are unable to accommodate more than 50 doctors without detracting from the value of the course. They would, however, like to remind practitioners that the next course will be held towards the middle of January 1961 and suggest that doctors apply for that course in good time.

Southern Transvaal Branch (*M.A.S.A.*). In place of the usual monthly meeting of the Branch, a combined meeting will be held with the Students Medical Conference of the University of the Witwatersrand on Tuesday 17 May 1960 in the Harveian Lecture Theatre, Medical School, Johannesburg, at 8.00 p.m. Dr. W. P. U Jackson will speak on 'Diabetes and the kindey', Dr. B. Senior on 'Renal tubular disorders' and Dr. D. Goldstein on 'Compensatory renal hypertrophy'. Prof. G. A. Elliott will be Chairman of the meeting and Prof. L. Eales, of Cape Town, will open the discussion session.

All members of the Medical Association have been invited by the Students Conference Committee to attend the evening meetings of the Conference held nightly at 8 p.m. between 16 and 20 May 1960. Full programmes will be sent to all members of the Association.

Dr. Maurice H. Luntz, M.B., Ch.B. (Cape Town), D.O.(R.C.P., Lond., R.C.S., Eng.), D.O.M.S. (R.C.P. & S., Irel.), F.R.C.S. (Edin.), recently of St. Mary's Hospital and Medical School, London, has commenced practice as an ophthalmic surgeon in partnership with Drs. O. M. Haarburger and Charles Goldin at 308 Dumbarton House, Church Street, Cape Town. Telephones: Rooms 2-6106, residence 77-1225, if no reply 69-2924.

Dr. Maurice H. Luntz, M.B., Ch.B. (Kaapstad), D.O. (R.C.P., Lond., R.C.S., Eng.), D.O.M.S. (R.C.P. & S., Irel.) F.R.C.S. (Edin.), voorheen van St. Mary's-hospitaal en Medieseskool, Londen, het nou as oogarts begin praktiseer in vennootskap met drs. O. M. Haarburger en Charles Goldin te Dumbarton-gebou 308, Kerkstraat, Kaapstad. Telefone: Spreekkamer 2-6106, woning 77-1225, indien geen antwoord 69-2924.

NUWE PREPARATE EN TOESTELLE: NEW PREPARATIONS AND APPLIANCES

TELCO

Westdene Products (Pty.) Ltd. announce that they have been appointed the sole importers and distributors for Telco Electronique Medicale et Industrielle, Paris, France, manufacturers of electronic cardiovascular diagnostic and survey equipment.

On view in their showrooms at 23 Essanby House, 175 Jeppe Street, Johannesburg, is a rack-mounted unit consisting of the following instruments:

1. An ECG amplifier 100% electronically regulated.
2. A 7-inch persistent screen oscilloscope giving 4 illuminated scales. Speeds ½-inch, 1-inch and 2-inches per second.
3. A 4-channel photographic recorder. The recorder gives automatic markings of time and ordinate lines. Galvanometers from 100 to 700 aps. It uses 120 mm. paper.
4. The M41 R electromanometer with its RA 8 transducer head for studying blood pressure by catheterization. The transducer has a multichannel tap and progressive hydraulic damping.
5. A MM41 R micromanometer with a minute transducer head fitted to the tip of a No. 8F U.S.C.I. cardiac catheter, used for recording pressure and sound of the heart at the same time. Incorporated in the catheter is a second lumen for blood sampling. It has no artefacts and no liquid column.
6. A CE4 4-channel electronic switch.

The unit measures: (*a*) Blood pressure from its standard transducer; (*b*) blood pressure from its microtransducer; (*c*) intracardiac sound from the microtransducer; and (*d*) ECG.

The 4 signals are displayed on the 7-inch oscilloscope screen and recorded on a photographic recorder.

For further information regarding Telco electronic equipment or suggestions for equipment for use in a particular field of medicine or surgery, please write to Westdene Products (Pty.) Ltd., P.O. Box 7710, Johannesburg, or telephone 23-0314.

ANOREXINE

Riker Laboratories Africa (Pty.) Ltd. introduce Anorexine, a new weight-reducer, and supply the following information:

Anorexine is specifically formulated to make weight-reduction more dependable and dieting easier for the obese patient. A single daily dosage removes all danger of lapsing from grace, where over-eating should be avoided. This easier adherence to the diet gives the patient great encouragement with, on the whole, better outcome to the weight-reduction programme which has been undertaken.

Slow release of the contained mixed amphetamines is obtained by an ion-exchange resin complex which eliminates all peaking effect such as is seen with ordinary tablet presentations. The slow-release resin complex is contained in capsules so that its integrity is not compromised by the compression forces met with in making the tablets, and anorectic effects are dependably sustained up to 14 hours.

Anorexine capsules consist of 1 part laevo-amphetamine *plus* 3 parts dextro-amphetamine, because these proportions have a better anorectic effect than any other combination, while the stimulation produced is minimal and just sufficient to prevent depression through dietary restriction.

Anorexine is available in 3 strengths: 7½ mg. capsules (white), 12½ mg. capsules (black and white), and 20 mg. capsules (black). These capsules are obtainable in packs of 30 (1 month's treatment) and 120 (4 months' treatment) and cost the patient, on an average, less than 4d. per day.

BRIEWERUBRIEK : CORRESPONDENCE

THE WRITTEN PAPER OF THE FINAL M.B., B.CH. EXAMINATION IN MEDICINE

To the Editor: Prof. G. A. Elliott's article[1] on the above subject was most interesting. In addition to finding it interesting I derived considerable satisfaction from being able to answer some of the questions set in the exams. Most of the elusive answers were found in text-books and my memory was refreshed. However, I am still unable to define 'haemoglobinopathy'!

The questions asked reminded me of trying to answer questions heard on popular radio quiz programmes. These programmes are favourites of mine because I know some of the answers and learn from other questions asked.

I should therefore like to suggest that you publish a regular quiz page in the *Journal*. I am certain that it would prove a popular feature, for it would not only provide a means of brushing up knowledge as well as teaching new facts and theories, but it would also be an aid to final-year students.

M.B., Ch.B. 1949

26 April 1960

1. Elliott, G. A. (1960): S. Afr. Med. J., 34, 333 (23 April).

THE WRITTEN PAPER OF THE FINAL M.B., B.CH. EXAMINATION IN MEDICINE

To the Editor: One South African university—if not others—accepts into the first-year medical course considerably more of the cream of South African youth—if selection criteria are thus indicative—than can be admitted to the facilities of subsequent years. These 'facilities' are grossly inadequate by modern standards. Admission to the second year is thus competitive against a figure even lower than that acceptable, as supplementary examination fees are good business.

This damage and abuse of a proportion of the pitifully small youth potential of South Africa is typical of the disregard South African universities have for their true function and duties. The sooner that faculties accept failures as indicative of their own deficiencies and rid themselves of the egocentric attitude typified by Examiner 'B's' excessive failure rate, the better. That an examination is necessary for more than perfunctory confirmation of faculty knowledge of individual ability indicates poor teaching, a disproportionate student-tutor ratio and a bad university.

The deficiencies of the medical curriculum are apparent to all; all power to Professor Elliott[1] and others who would change it.

R. G. Drummond

Coalbrook South Colliery
P.O. Coalbrook, O.F.S.
27 April 1960

1. Elliott, G. A. (1960): S. Afr. Med. J., 34, 333 (23 April).